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THE CHILD

AUGUST–SEPTEMBER 1950

to JUNE–JULY 1951

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BETTER HEALTH FOR SCHOOL-AGE CHILDREN

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a challenge to medicine and education

LEONA BAUMGARTNER, M. D., *Associate Chief, Children's Bureau*

MEDICINE AND EDUCATION have always had much in common, but in recent years they have come closer together in the fundamental concepts which underlie their approach to the specialized problems with which each deals.

Both, obviously, serve people. Both influence the behavior and attitudes of people, adults as well as children. Both are concerned with the growth and development of well and sick human beings. Both are motivated by a desire to contribute to happy and vigorous living.

Today's educator and doctor, thanks to their own better understanding of the way human beings grow in physical and mental health, and thanks to the contributions that science is making to everybody's thinking, are aware that they must deal with the whole body and person of a child, not just with a part of his anatomy or a fraction of his life or education.

Education has come a long distance from the days when it measured its success by the number of facts it had crammed into a child's head. It is recognizing that its real job is to prepare a child for living in a constantly changing world—a world in which the magic of science and the gadgets of living not only fascinate us but threaten our very lives. Educators know now that a child's attitudes toward himself and his neighbors, his capacity to meet new conditions and new relations, are vastly more important than knowing what happened in the year 1066—more important in terms of his own living and in the lives of those around him.

Similarly, psychosomatic medicine has made doctors more aware that a child's health is not necessarily just a problem of absence of germs or viruses. What happens to a child in school may produce an illness every bit as serious as an illness of definitely physical origin. We know, too, that a well child is not just a child who has no visible handicaps, or has no identifiable aches or pains.

What we are after, both educators and doctors, is to help in rearing a new generation of human beings who are buoyantly healthy in body and spirit; whose creativeness and sense of social responsibility are given the greatest possible opportunity for expression; who have an unshakable conviction of their own worth and the worth of other people.

This is the kind of positive health that we—as educators and medical workers—are after. This is the quality of people who, we are convinced, can build a truly democratic society. And that is the society we are intent on cultivating in our time, the kind of society we believe in.

Happily, we have reached the stage where doctors and school people who want to do something constructive for the better health of school-age children are receiving encouragement from citizens generally. A great deal of thought and planning is going to be focused this year, and in the immediate years ahead, on what to do and how to do it. I am convinced that all of us have a great deal to contribute to this thinking and planning.

But what are the facts that doctors and educators must face as they plan for the future health of our school-age children?

The first fact is that the health problems of these children are not what they used to be.

School medical services in this country are said to have started in 1894 in Boston and in 1897 in New York. The chief reason for establishing such services appears to have been the fear—and, indeed, the actuality—of contagious diseases. Not much was expected of the earliest medical service in schools. If it inspected children, and barred from school those who showed signs of contagious infections, it accomplished its purpose.

As the years have passed, and as other techniques for dealing with the common contagious diseases developed, the need for this kind of routine has all but disappeared. Diphtheria, to take but one example, a dread disease a half century ago, has been practically conquered—and not only by the device of examining school children, but chiefly by immunizing children in infancy. In 1900 the death rate from diphtheria was 40 per 100,000 population. Now it is less than 1 per 100,000—a tremendous reduction.

But present-day interest in making school medical services more effective for children arises not merely from the fact that we have about conquered the contagious diseases. We realize now that many other conditions handicap-

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Condensed from an address made at the one-hundred-and-sixteenth meeting of the American Association for the Advancement of Science, convened in New York City.

ping children need attention, and that some of them are not detectable by the old-fashioned routine physical examination in the school, which was the foundation stone of the school medical service in the first decade of the twentieth century.

The Children's Bureau estimates that among persons under 21 years of age in the United States some 175,000 have cerebral palsy and 200,000 have epilepsy—neither condition, so far as we know, being contagious—conditions often ignored by routine medical services in schools. But these children not only need the best that medicine and education have to give, but in the vast majority of instances, can profit from that best. A half million children have handicaps requiring orthopedic or plastic treatment. Some of these children are receiving good care, either privately or under the auspices of State crippled children's programs, which since 1935 we have recognized as deserving the support of the Federal Government as well as of State and local governments. The Children's Bureau apportions to the States the funds that Congress appropriates each year to extend and improve these State programs. But despite the devoted service given to children by State crippled children's agencies, they are being forced every year to turn down thousands of children whose crippling condition could be improved, simply because there is not enough money. For example, at the beginning of 1949, the States reported that they knew of 30,000 crippled children who would have to go without the medical or hospital care they needed unless additional funds were forthcoming.

And what of other crippling conditions among our children of school age—poor hearing, poor sight, poor teeth, and so on? We do not know how many of these children are getting the treatment they require, but any teacher can tell you of at least one child who needs more or better care for one or more of these conditions than he is now getting. It doesn't make sense to force a child to go to school when he can't see the blackboard or hear the teacher.

I know youngsters—and I am sure everybody does—who are so worried over problems at home that they just can't settle down to their lessons. We are beginning to realize that they, too, are a "school health" problem.

Some investigators feel that the major problems of children of school age today are emotional. Others feel that we have not sufficiently recognized the extent to which nutrition plays a role in the health of the school child. At any rate, it seems clear that the health problems of children of school age are not what they were when most of the present health services in schools were set up. Some old problems do remain, however, of which hearing and vision probably rank first. In passing, it is of interest to note that the problems of ridding the child of specific disease may be of less concern than those of adding to his well-being.

A physical examination should be followed by remedying of the child's defects. If, however, the examination leads to nothing but a letter sent to the child's parents, it is often wasted.

This leads us directly to the second fact that faces doctors and educators in planning health services for school-age children—that although we know a great deal more about curing and preventing illness, we still do not know enough to do the good job we should like to do.

To be sure, we can take great pride in the distance we have moved since school medical services were first established. Of all the periods of life, school years are the healthiest. As I mentioned earlier, the common contagious diseases of children have been all but conquered. Antibiotics and the sulfa drugs have almost eliminated infections and pneumonia as causes of death and have prevented the complicated mastoid operations. New drugs have made the life of the asthmatic child much more comfortable, and new drugs can control epilepsy so that many children with this condition can now go to school just as their nonepileptic brothers and sisters do. We now know how to use surgery to save the child with congenital cardiac disease from death and to give him a chance to lead a normal life. We have new tools to control dental caries—adding fluorine to the water supply and applying fluorine directly to children's teeth—that may reduce caries by as much as 40 percent. We have new understanding of the physical and emotional growth of normal children, and we know how to help children avoid some serious behavior problems. But every educator and every doctor can tell you of a child with a physical or emotional health problem for which we seem to have no solution at present.

Two major difficulties need special emphasis: (1) Accidents are the leading cause of death for children over 1 year of age. Some excellent work on accident prevention is going ahead, but we still do not know why it is that some children *seem* so much more prone to accident than other children. The deep psychological problems inherent in this should be explored. (2) Among all diseases, rheumatic fever is the leading cause of death in children of school age. Probably a half million children right now have this disease or have had it. Some thrilling developments in the treatment of rheumatic fever, by cortisone and ACTH, are going on, but we still do not know enough about the underlying cause of this disease to prevent it.

Research in the whole field of child growth and development is moving ahead, but slowly. For people who have been so generous in their support of research in the physical sciences, we are niggardly, indeed, in supporting research into the most basic problems of mankind—the problems that human beings encounter as they grow—or fail to grow—emotionally and socially, from infancy into adulthood.

Two years ago the Federal Government was spending, with congressional approval, $625,000,000 for research. Only about $28,000,000 of this was in the field of the health of human beings, and only a few thousand on problems of child health. This situation, as far as children are concerned, is little better today.

We need more research

Research, like the control of contagious diseases, has become, at this midpoint of the twentieth century, the people's business; that is, something that all of us must help to finance, something on which all of us must have our say. Research increases our skill in the business of helping children grow up healthy and happy. We must put to work all the scientists in the field of child development we can find—and there are too few of them—to help us discover how we can best cultivate in children those qualities of heart and mind that make for individual security and responsible citizenship. And specifically for school services, we must determine by scientific methods what the real problems of children of this age are—and then plan accordingly.

A third fact that doctors and educators face as they get down to the specifics of planning for the better health of school-age children is this: Present health services in schools not only are built largely on the beliefs of a quarter-century to a half-century ago; but they are haphazardly set up. They are set up so haphazardly that we cannot be sure that the children most in need of medical care get it.

The most informative and significant body of facts about what is actually being done for the health of children in this country was recently published by the Commonwealth Fund, under the title, "Child Health Services and Pediatric Education." This volume reports on the first Nation-wide survey ever made covering health services for a whole segment of our population. Both the method and the extent of this study, a cooperative undertaking by the American Academy of Pediatrics, with the Public Health Service and the Children's Bureau of the Federal Security Agency, were unique. Pediatricians themselves were the principal fact-gatherers.

According to the report of this survey, about half the counties in the United States have no school that offers a health examination by a physician. Anyone planning health services for school-age children must also face up to the kind of health care these children get outside of school. The Academy study showed that children in New York receive more than twice as much care as those in Alabama, not because New York children are more frequently sick but because medical-care facilities are more plentiful in rich States and communities. Children in isolated counties receive one-third less medical care than those in or near cities. For every 1,000 children in greater metropolitan areas, there are nearly 6 doctors; but in isolated areas, only between 1 and 2. In metropolitan and adjacent counties, there are 15 hospital beds per 1,000 children; in isolated counties, there are 8. States with low income and few services have a larger percentage of their population in children than do high-income States.

Every community resource for meeting the health needs of children must be considered in any sound plan for children of school age. We have, I hope, grown away from the notion that a program of health services for such children can be an isolated thing, unrelated to what we are doing for children outside schools and for children of all ages. The health problems of school-age children start with conception, not on the day they are registered for their first year in school.

Who should do what?

All this leads me to suggest there are six problems that we must resolve before we can go forward in building a modern, rational, and competent plan for the better health of our school-age children.

We need, first of all, to resolve a disagreement that has been hampering the development of good school health services for years. This controversy between educational and health authorities as to *who* is responsible for *what* services may have been inescapable in the past. By now it ought to be possible to resolve it, and I think we can do this on the basis of the general formula that was suggested by the Maternal and Child Health Section of the National Health Assembly, which met in Washington in May 1948.

". . . Differences of opinion," said this section in its report, "largely reflect an attempt to adhere to the dictum of single-agency administrative responsibility. Compliance with this dictum is impossible because, on the one hand, educational authorities have basic administrative responsibility for all activities taking place in the schools; and, on the other hand, health authorities have official responsibility for activities for safeguarding and promoting the health of all the community.

"The solution," continues the report, "lies in the direction of joint program planning and execution which recognizes the responsibilities of each agency and its respective area of competency. For example, the circumstances under which child-health examinations will be carried out are a matter of joint planning; the technical conduct of the examination and plans for corrective care are the responsibility of the health authority; whereas the use of the results of the examination for instruction is the responsibility of the educational authority."

I hope we can do more thinking along such rational lines as these. I hope we

Discussion of a child's health problems by nurse and teacher is a step toward solving them.

can stop bickering at the expense of progress in better health services for school-age children.

Another problem on which we must do some thinking is the relation of treatment services to examinations. Only in certain places and for specific conditions is there any adequate tie-up between the two at present. But a health examination that reveals a bad health problem in a child and ends with a letter to that child's parent cannot possibly be considered an adequate discharge of our social responsibility for good child health. It has shocked me to learn, for example, from some studies how children pass through some of our health examinations in schools, only to come back, at the next examination, with the very same defects that showed up earlier. In one State, for instance, of the 37,000 children found to have something wrong with their eyes, fewer than 8,000 children had had corrections by the time of the next examination. That kind of follow-up seems far from satisfactory. Certainly, knowing that children have defects is of little value unless we do something about correcting them.

We have an extremely complex situation before us in trying to figure out how we should go about insuring that something is done for the child who shows up in school with poor eyes, or poor teeth, or a bad heart, whether that condition is discovered in an examination on the gymnasium floor or in the doctor's office, or is merely suspected by the teacher or parent. The whole interrelationship between public and private services is involved here. Whose responsibility is it to assure good health for children? The delicate problem of how some parents can be persuaded to put a higher priority on the health needs of their children comes up. Is it really all a matter of persuading parents to put more of their money and concern into getting children to hospitals or doctors? How about those areas where really good diagnostic and therapeutic tools are not yet available? And behind both is the question: How much responsibility will all of us as citizens take to assure, through the taxes we pay, the availability of good health services where they do not exist now?

School work and good health

To me it seems stupid for us to pass laws forcing children with physical and emotional handicaps to go to school, to send truant officers after them when they are absent, and to flunk them out when they fail in their lessons, or spend funds to have them repeat grades, if, at the same time, we do little or nothing to help them with their health problems. And here I am speaking of both physical- and mental-health problems. We don't behave that way when we pass laws requiring men to serve in our armed forces. We make sure that they are *able* to do what the law requires. We ought to be even more scrupulous with young children.

Maybe those who are concerned lest these new ideas cost us too much or lead us to greater dependency on the State should take a look at the high cost of the penal and reform institutions we are maintaining for the care of adults, many of whose troubles might have been avoided if they had had the care they needed as children. And there is also the high cost of care in hospitals for adults with chronic illnesses, mental and physical. Of one thing I am sure, the further improvement of the health of our school-age children demands that we focus sharply on the problems of organizing our health resources to the end that a more effective scheme of getting results is evolved.

Still another problem has to do with research. I have touched on this before, so I merely mention it here again and in another connection. As an administrator of local and Federal programs for child health, I know how often those doing the job need more than a new drug to control a disease. They need research on the basis of which standards and guides can be developed against which to test practices. Administrators are too busy usually to develop these. Not all have the objectivity needed to work them out. If health services for school-age children are to be soundly developed, they must be constantly fortified and enriched by constant evaluation.

And then there is the problem of the shortage of trained personnel. The Academy of Pediatrics found that half the general practitioners in the country—and they supply three-quarters of the medical care children get from private doctors—either have had no hospital training in the care of children, or have had less than a month of such training. As in our total health problem in this country, we are right up against the hard fact that too few young people choose health services for their careers, and too few of those who do choose them get specialized training in the needs of children. Until last year I think no school of medicine or public health had specialized courses for doctors who wanted to do "school health." Any sound program of health services for children of school age must make provision for more and better training, as well as for more and better service.

Next on my list of problems is the

relation of school health programs to the whole community health picture. Every educator and doctor dealing with a 6-year-old who is in trouble knows well how often the roots of the trouble go back into that child's preschool years. Most of us wish we could have been in on the trouble at the beginning to help both the child and his parents. We are not really going to build better health in school-age children if the services we provide them are developed in isolation from, or in competition with, our health program as a whole. It is time we faced up to this.

Finally, we are not doing as well as we should in helping parents with the rearing of children. Probably never before were parents so eager for guidance and assurance on their job as they are today. While there are many excellent demonstrations of close teamwork between doctors, educators, and parents, we need to multiply these many times, to spread them far and wide over the country. No one can dispute that the better understanding of infant care by parents has contributed greatly to reducing infant mortality in this country from 10 deaths per 100 live births in 1915 to 3 per 100 live births last year. Parent education was not, of course, the only factor in bringing about this great improvement, but it certainly was one factor.

We need more than parent education, of course. We need to make parents full-fledged partners in the development of our health services for school-age children. How we should go about that deserves our best thinking.

We should join our forces

Here, then, are six specific problems on which we must work if we are sincere about facing the health needs of school children. Here, indeed, is common ground on which educators and doctors can and must meet. The health of school-age children demands it. Now is the time to forget our differences and to join our forces.

Our national health and strength are much like stands of tall timber. We cannot take from them more than we plant without imperiling our survival. We must summon all our talents, all of our wisdom in education and in medicine to build sturdy mental and physical health for all of our children.

WHAT HEALTH SERVICES DO SCHOOL-AGE CHILDREN NEED?

THOMAS E. SHAFFER, M. D.

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A CHILD born this year may expect to live to the age of 67 years. After he reaches school age and has safely behind him the risks associated with birth and early infancy, he may expect to reach an age of slightly more than 70 years. This is a priceless gift that scientific progress has bestowed upon him when one compares it with life expectancy of 50 years for the child born in 1900, and of 39 years for the one born a century ago.

Vital statistics such as these are heartening but they are not a conclusive measurement of the health status of people in this country. First, long life does not come to everyone just because of a statistical probability. Many who are children today will fail to reach the expected old age because the fruits of scientific advances are not available or because advantage of them is not taken.

And what about children who will live a full span of years? Is it enough simply to live 70 years? Certainly not if through those years one suffers from handicaps which might have been corrected or reduced. Longevity is not a reward sufficient unto itself in these days when the possibilities of optimal health are beginning to be appreciated.

If the goal of a full life is to be reached, the child of school age deserves added attention. The opportunities for improving health during this period have long been neglected, mainly because at this age the handicaps often are not conspicuous and not apparent in mortality statistics. The years between 5 and 17 are, in fact, the safest period of life if the threat of fatal illness alone is considered. This is no reason for complacency, however. The school age is marked by a host of physical and emotional disabilities which, though they do not endanger life, interfere with the best growth and development. Some of these handicaps could be prevented and others, if discovered in time, could be overcome. Even in the case of those advanced beyond correction, much can be done during the school years to lessen their effects. For many children the school age is notable as a period of unrealized potentialities.

The spotlight of scientific study, focused in the past on saving lives, is now turning toward ways to improve the health of people of all ages. School and community-wide health planning for children is being developed and certainly will receive increasing attention in years to come. It is fitting to reflect upon some of the features this planning for health improvement should include.

Health services for children of school age, if they are realistically conceived, will make use of up-to-date medical practices and will focus attention on the health problems that are known to occur frequently in this age period. All practical measures contributing to prevention of ill health and promotion of better health would be included, along with diagnostic and treatment services for those who need them.

Stressing preventive services

In all medical fields today there is pronounced emphasis on prevention and the more dynamic subject of health improvement. Advances in diagnosis and treatment have led to better understanding of the causes of poor health and ways to prevent it. Conditions for which, not long ago, there seemed no control except treatment are now looked upon as preventable. Once limited to sanitation, immunization, and quarantine, preventive medicine now offers a great deal to people of all ages and to school-age children in particular.

Beyond immediate control, but a major factor in the prevention of poor health in the school age is the influence of a child's family. The best promise of health a child can have is to be born of emotionally mature parents who are sufficiently loving and tolerant to accept him as he is and who are convinced of the value of continuous health supervision. This is the basic foundation of good emotional and physical health, without which no other measures will be completely successful.

Children who have this family background will have less need for treatment in the years to come. We can offer a preventive service to the children of the next generation by preparing today's children to be better parents when they grow up. A great many of the emotional disorders seen during the school years are brought on by the attitudes and actions of well-meaning but poorly prepared parents. Many of the physical health problems in this age group have become more difficult because parents have not realized that health supervision of their children in their doctor's office or in a public-health clinic is desirable throughout childhood.

About 90 out of every 100 children need dental treatment, and it has been estimated that tooth decay is occurring about six times as rapidly as it can be attended to at the present time.

As the child grows older

The health problems of the child of school age that are within the reach of prevention are in some respects identical with those of younger children. Other risks, however, result from the child's becoming more and more independent and leaving the environment of a small family unit to join larger groups in school and in his community. The most needed preventive services are those that are aimed at controlling the following prevalent conditions: (1) tooth decay, (2) accidents, (3) emotional disorders, (4) malnutrition, (5) infectious diseases, (6) unhygienic environment, and (7) insufficient convalescence after illness.

Dental decay is so common among children that it seems hopeless to try to keep up with it by treatment alone. About 90 out of every 100 children are in need of dental treatment, and it has been estimated that tooth decay is occurring about six times as rapidly as it can be attended to at the present time. The application of sodium-fluoride solution to healthy teeth at intervals of 3 to 4 years is a preventive procedure which promises to reduce the treatment problem to one which can be coped with more easily by the dental profession. This is a much-needed measure for the control of a widespread disease in childhood, which should be available to all.

We can help children to be safe

At practically every age during the school years *accidents* cause more deaths than any disease. Most accidents can be prevented and undoubtedly will be when their toll is appreciated. The rewards would be as measurable as those from immunization against the preventable diseases. In all our thinking about the health of children in the school age, priority should be given to teaching them how to swim, ride a bicycle, and drive a car, and to removing hazards which increase casualties. Accidents are particularly apt to occur in schools and on playgrounds because of the stimulus of group play and the demands of young bodies released from enforced inactivity. Thoughtful planning for safety is especially required in these situations.

Emotional disorders exhibited in "behavior problems" due to unhappiness and fear are so common during the school years that some authorities say one in every five school children needs expert help in order to regain his emotional health. Attitudes and reactions that lead to emotional illness are undoubtedly due more to home conditions in early life than to any other influence, but there are times when they are initiated or aggravated outside the family. Schools especially, and other community groups as well, have an opportunity to promote emotional health by considering each child as an individual with particular capabilities which can be developed, and further by helping parents to see their child in the same light.

Unrecognized *malnutrition* is surprisingly common among children during the school years, primarily because

Happy and understanding teachers, by creating a good emotional environment in the classroom, contribute as much to children's health as do the physical factors in the school environment.

only a minority of children seem to eat enough of the right kinds of food. An added factor is the harmful effect of physical and emotional illness upon nutrition. One of the main reasons why deficiencies in nutrition have not caused enough concern is the general reliance on a child's weight as a good index of nutrition. As body weight is largely an indication of the amount and not the kinds of food in the diet, serious deficiencies of one or another essential substance in the diet may be present while the child actually gains weight.

Detection of malnutrition is often difficult, and this condition may exist many years unnoticed. The logical way to solve the problem of malnutrition is to try to provide an adequate diet for all children so that subnormal health and need for treatment do not develop. The ways to do this will vary with circumstances. Some parents simply need to know more about the variety of foods a child needs for growth. Many times, however, they need aid in obtaining a diversified diet which does more than appease hunger. Schools have a chance to help solve the problem through their school lunch, which could go a long way toward making up lacks in the children's diet at home.

Those *infectious diseases* which once caused so many deaths among children of school age have now been brought under control through immunization and modern methods of treatment. Every child should have the advantage of immunization against smallpox, diphtheria, whooping cough, and tetanus. Protection against the first three of these is not merely a matter of personal concern, because a child who contracts one of them is a source of infection to everyone around him. These immunizations, and that for tetanus (because it can be prevented but not treated satisfactorily) should be available to all children from some source, whether a private physician, a health conference, or a public-health agency. Ideally, initial immunizations would be completed during infancy so that stimulating doses only would be required during the school years. Children who have not been immunized should be given this protection as soon as possible, except that when whooping-cough immunization has been delayed until the child is 5 years old it is questionable whether this step should be urged.

Fortunately most of the communicable diseases that threaten life are preventable. The milder contagious diseases of childhood, and colds, are exceedingly common, and cause more than half of all school absences. At the present time there are no specific measures for the control of these diseases. Experts agree that much more research is needed before the use of ultraviolet lamps and glycol mist vaporizers can be recommended. Current enthusiasm for preventing colds by drugs that are primarily effective in allergic conditions must be looked upon with the same caution.

One service much needed for the promotion of health is the furnishing of *wholesome surroundings* for children in all their activities. Good lighting, proper heating and ventilation, sanitary toilet facilities, clean rooms, pure water and milk, uncontaminated food, teachers and bus drivers who do not have tuberculosis or other contagious diseases—all of these are taken for granted many times when they are not guaranteed at all. In the home, at school, or elsewhere in the community, the health of children is vulnerable to conditions in the environment which can be controlled. It is worth remembering that happy and understanding teachers, by creating a good emotional environment in the classroom, contribute as much to children's health as do the physical factors mentioned above.

It is a paradox that so much time and enthusiasm have been spent on trying to control colds and related diseases while scarcely any thought has been given to helping children during *convalescence from illness.* Parents have some responsibility in preventing a child's precipitous return to activity, but schools can do even more by giving pupils a chance to get back gradually into a full program after an absence due to illness. School schedules cannot always be elastic enough to give every child an individual program, but work missed during illness, and participation in the regular recreation and physical education programs, can usually be postponed several days until recovery has progressed further. The tendency to return children to school too early in convalescence is magnified when school appropriations are based on average daily attendance.

Preventive medicine depends to a large degree upon the amount of health information children and their parents have. Health education in schools and elsewhere in the community is in the same category with other needed preventive services, as it leads to attitudes and actions that make the services more effective.

Preventive services not enough

Unfortunately preventive services do not guarantee good health for every child, even when they are most effectively applied. On account of heredity, or of other factors beyond control, there will always be some children who need medical care. The acute or sudden illnesses, though common, are usually soon apparent and are not difficult to diagnose. It is a challenge today, however, for us to find children of school age who are suffering from an unrecognized handicap or one believed by them to be hopeless, so that they too may benefit from the medical advances of recent years. This is indeed a problem of no mean proportions in view of the fact that among our children of school age there are millions with defective vision, with impaired hearing, with imperfect speech, or with significantly poor nutrition. In addition to these children, there are many thousands of children with cerebral palsy, epilepsy, residual effects of poliomyelitis, congenital heart disease, and birth injuries. These conditions, for which treatment or rehabilitation is so necessary, might easily be neglected until their effects cannot be remedied.

Discovery of children in need of medical attention is not a task for medically trained people alone. Parents, teachers, nurses, social workers, and many others who are closely associated with children frequently can steer those with health problems into the channels that lead to diagnosis and treatment. Mothers and fathers are usually expected to be alert to signs of ill health in their children. Others outside the family can be equally observant of any unusual behavior or appearance that leads to a suspicion of impaired health.

In addition to continuous vigilance by those who are with children a great deal of the time, a few important survey or screening tests are needed, preferably at yearly intervals, to disclose conditions that are not readily apparent to observers. The most significant screening technics are tests for visual acuity; a hearing test with an audiometer; determination of height and weight to learn whether growth is occurring; and chest X-rays of boys and girls who have reached adolescence.

Complete physical examinations have been looked upon traditionally as the bulwark of a case-finding program in the school years. The value of thorough examinations cannot be denied, for they do disclose conditions which can rarely be suspected in any other way. But when professional services are limited, there is a danger of overemphasizing medical examinations and inspections to the detriment of equally important preventive services and follow-through on children already known to need remedial services. After a thorough examination and health conference to establish a base-line of health status, a plan of continuous observation and screening tests bearing on common health problems, supplemented by examinations judiciously performed when there is suspicion of ill health, is usually more reasonable than repeated routine examinations.

All the skills and technics modern medical science offers are needed by the child with a suspected health problem. Research has advanced the understanding of physiology and of disease but at the same time it has made diagnosis more complex. Diagnosis nowadays usually requires resources not found in schools or even in the average physician's office. Treatment, however, depends on accurate diagnosis, so that the advantages of laboratories and diagnostic equipment and the services of specialists are as indispensable today as was the fever thermometer in bygone times.

The benefits of accurate diagnosis are not limited solely to children who need treatment. There are also those who are temporarily or even permanently consigned to the ranks of the sick and disabled on insufficient evidence. Adequate study of such children returns a host of them to normal pursuits without any need for treatment. An outstanding example is seen in the investigation of children with heart murmurs: In the final analysis only about 1 out of 15 or 20 children with such murmurs

As part of our safety planning for children of school age we should teach them not only to avoid injury, but, in case of minor hurts, how to take care of themselves as far as possible.

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SCHOOLS ARE A FERTILE FIELD FOR MENTAL-HEALTH EFFORTS

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QUITE A VARIETY of methods have been utilized, alone or in combination, in the cause of mental health in schools.

A few wise boards of education have child-guidance clinics of their own, with psychiatrists, psychologists, and psychiatric social workers. A psychiatric team within a school system can handle referral and treatment of cases efficiently. But there must also be a real effort to carry the meaning of the child's problem back to the principal and the teacher who made the referral so that they can learn how to do their part for the child and others like him. In addition, the psychiatric staff can provide more formal training for the teachers, administrators, and nurses. The emphasis in such training should be on normal emotional development and the meaning of common minor disturbances rather than on the more serious diseases.

Some other school systems, which do not have a psychiatric staff exclusively their own, do have some claim on local psychiatric facilities. This is important even when there is little cooperation and exchange of information between the two institutions. For, if the school system attempts to set up any kind of guidance program with trained, though not psychiatric, personnel, these workers will be perplexed and frustrated by the occasional child who is really disturbed and whose problems are beyond the scope of the guidance personnel unless they can have psychiatric supervision or consultation.

Most noticeable among efforts to improve the mental health of school boys and girls has been the growth in the last two or three decades of guidance or counseling programs. These vary greatly in scope. Some are highly developed and effective; others are hardly more than gestures. The best programs are directed and integrated by full-time guidance counselors. In others the principal or assistant principal doubles as director of the program, and the classroom teachers double as counselors.

Although the figures available do not present an accurate picture, some idea of the status of guidance programs in schools may be gained from the fact that the number of trained guidance workers in schools in the United States increased, between 1937 and 1945, from 2,000 to 8,000. In one State, New Jersey, the percentage of schools claiming some type of guidance counselor increased between 1930 and 1947 from 42 percent to 99 percent.

To obtain a realistic picture, we must, of course, look beyond statistics. For example, a recent survey of high schools in the North Central States seemed to show that 75 percent had the minimum essentials of a guidance program. The actual incompleteness of many of these programs, however, is indicated by the fact that though 7 out of 10 schools said that classroom teachers were responsible for part of the counseling, only 1 out of 8 gave the teachers free time for it. One in 3 gave reading tests, but only 1 in 7 discussed the implications of these tests with the pupil. Only 1 in 5 had a trained full-time worker in charge of guidance.

The nature of the guidance varies too. For example, in one program the help offered is confined to psychological testing and remedial tutoring. In another it is largely vocational testing and guidance. In the best programs an effort is made to take cognizance of the total adjustment of all pupils and to cope with maladjustment in any sphere.

Another indication of the growth of guidance services is the steady increase that has been taking place in the number of universities offering courses in counseling and in the number of candidates for training.

A psychiatrist would be concerned not only with these visible inadequacies in guidance programs but also with the philosophy of whatever guidance is given. How deep does it go in understanding the roots of the child's problem, whether it is reading disability, indecision about future occupation, or social self-consciousness? Without depth of understanding, the adviser cannot be of much help and may occasionally do harm.

When I was first being told about the functions of the school counselor by that wise educator Caroline Zachry, I, feeling that even the most thorough of psychiatric training did not necessarily produce a sound psychotherapist, was shocked at the idea that persons without any training concerning mental disease would be dabbling in guidance.

Dr. Zachry patiently pointed out that there is no such thing as *no* guidance, *no* treatment. The school, like the home, reacts to each child's problem in some way or other, wisely or unwisely, knowingly or unknowingly, and it is better in the aggregate for the school to be making efforts to understand and help, even though these efforts often miss the target. Dr. Zachry believed, as physicians and others do, that schools should have the services of a psychiatrist, on a full-time, a part-time, or a consultative basis, to back up the counselors.

One worker who has done a great deal for the adjustment of boys and girls is the public-health nurse, who has worked hard in our schools for many years. Often she has been the main link between home and school, gathering valuable information for the teacher, interpreting school policies to the family, helping both parent and teacher to understand the child better and thereby to handle him better. In this work she has been a potent aid to mental health, whether she thought of it that way or not.

Now, like the physician and the teacher, she wants to know more explicitly about human relations and emotional development and behavior disturbances. She needs this help not to branch out into new lines of work but to do more wisely the job that she is already doing.

Some school systems have obtained the services of social workers to provide a skilled liaison between school and home, and have been enthusiastic about the results. The school social worker brings to her work a training in interviewing, and in dealing with human relations, which is not usually provided in the training of the public-health nurse; and she lacks, of course, many of the nurse's skills. Yet both are valuable in the field of mental health: there is plenty of work, and to spare, for both. If they are both utilized in the same school system, there is much they can teach each other.

The clinical psychologist certainly has a vital role in the school system. Intelligence testing, achievement testing, diagnosis of disabilities, and remedial work are all basic to understanding and planning for the child's educational and emotional needs. The psychologist's usefulness, like that of other workers with children, depends most on his soundness in understanding and handling the emotional aspects of their problems.

Both the psychologist and the school social worker can work more efficiently and safely when they have the opportunity to collaborate with a psychiatrist.

Remedial teachers also have a great mental-health contribution to make to pupils, since a reading disability can shatter a child's adjustment as quickly as any other factor. Since emotional factors, primary and secondary, often are tangled with the presumably constitutional factors, such remedial work is most reliable when combined with psychiatric evaluation and treatment.

Another approach to mental health in schools is the inclusion of the subject in the curriculum, just as physical hygiene has been there for a long time.

A sampling of the contents of mental-hygiene courses shows a wide variety of topics handled and a wide variation in basic philosophy, as would be expected. Some provide sensibly for class discussion of everyday problems like etiquette, dating, popularity, common worries and concerns in adolescence, family relations. The value of such a course depends on the attitude and skill of the teacher, his own wholesomeness, his sensitivity to adolescents' feelings, his success in evoking student discussion. Some other courses get lost in impersonal discussion of factors in mental health and disease which have no meaning for children.

The wise educator and psychiatrist would question putting the main emphasis on a single separate course, just as they question the advisability of compressing sex education into a separate course. They insist that the relationships between men and women and boys and girls, the relationships between parents and children, the relationships of the individual to the world and to himself are not peripheral subdivisions of life but the very core of life itself. If so, they should be the core of the curriculum, from nursery school through professional school.

In other words, mental health in the sense of multiple adjustment to life is something that can be practiced and learned about all day long, all childhood long, if the teacher understands children and her job. She develops interest in school work by gearing it to her pupils' level and angle. She develops a sense of responsibility by allowing fullest student participation in choosing, planning, and executing the year's projects; she fosters respect and affection among pupils by helping each subgroup and committee of the class to find and call forth the best capabilities in each individual.

As the curriculum becomes more crystallized in the upper grades, there is still opportunity in most subjects to start with the human aspects and to let the students bring it back again and again, in discussion, to their own lives and feelings. There is room for discussion of vocational adjustment in geography, in history, and in chemistry. There is sex education in the broadest and best sense in "Idylls of the King," as well as biology, if the teacher will let the students bring it out. When these opportunities are lost, the result is not just a zero increment to mental health; there is a subtraction from it. When the biology course postpones getting around to human beings till the last month, and nervously skimps study of the reproductive system in the last two

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The school, like the home, reacts to every child's problem in some way, knowingly or unknowingly, and it is better if the school tries to understand and help, even though it may fail.

TO HELP THE CHILD WITH A SPEECH HANDICAP

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AT LEAST 2 million school-age children in this country have serious speech disorders. Definitions of defective speech vary greatly, but we are not here concerned with mild and unimportant imperfections in speech, which are very common, of course, particularly at the younger age levels. At the age of 6, for example, the average child still does not produce 10 percent of the speech sounds correctly, but we do not call this average child a speech defective on this account. In fact, for purposes of the present discussion, we are not talking about any child who is below school age and we are concerned only with children above the minimal school age whose speech is so distorted, blocked, or undeveloped as to penalize the child significantly with respect to educational progress and basic development as a normal social being.

Speech defectives, on the whole, make up the largest single group of seriously handicapped children in this country.

Among every 10,000 school-age children there are, by conservative estimate, about 700 with speech and voice disorders of educational, vocational, and personal or emotional significance. Of these, 400 have disorders of speech-sound formation (articulation); 150 have speech and voice disorders associated with serious hearing loss; 60 stutter or stammer; 50 are seriously retarded in speech development; 20 have speech and voice disorders associated with cerebral palsy or other neuromuscular impairments affecting the speech mechanism; 15 have other significant voice disorders; and 5 have speech and voice defects associated with cleft palate and harelip.

Of these 700, approximately two-thirds (about 500 per 10,000, or 5 percent of the school population) are to be classified as speech defectives only; that is, aside from their speech difficulty they are, as a group, physically and mentally normal. The other one-third have speech or voice problems that are associated with some other handicapping condition, such as a hearing loss, cleft palate, or cerebral palsy.

Speech defect brings frustration

Next to caressing and fondling, speech affords the most intimate exchange of feeling between mother and child and also between the child and other persons, young and old, closely associated with him. The failure of speech to develop, therefore, or the grave distortion of its normal forms, deeply frustrates the child in his struggle to achieve the sense of security and social belonging that is essential to his healthy growth as a human personality.

This means chiefly that when adult speech defectives are closely studied it is found that their established patterns of social adjustment are those of fundamentally normal persons who have had to contend with persistent and demoralizing frustration in their attempts to compete with and cooperate with other persons. They have been affected by their speech frustrations in ways that have led, in many cases, to difficulties relating to love and marriage, to serious educational handicap, to a probable average loss in earning power of more than 25 percent, and to feelings of discouragement and inferiority that are important in ways that all of us can deeply appreciate.

It is clear to all who will spend a

If a child has a speech disorder, the earlier in life we start remedial instruction the better.

moment in thoughtful reflection that for the vast numbers of children who need speech correction, nothing else our schools offer these children can compare with it in importance.

It is to be greatly emphasized from a practical point of view that the speech handicapped, as a group, are capable of being rehabilitated in large measure, provided they are given the best remedial instruction now available. What is even more important is the fact that in the kindergarten and in the early grades preventive programs can be very effective. In children who have developed speech disorders, the earlier in life remedial instruction is started the better.

In all probability not over 10 percent of our school children who need speech correction are getting it today. In fact, there are stuttering children in this country who would have to travel a thousand miles or more to reach a clinic in which they might expect to obtain substantial benefit.

For a quarter of a century the American Speech and Hearing Association has devoted itself to the needs of the speech handicapped. It has worked effectively to improve standards and to develop more and more effective methods in speech correction. Information from this association indicates that there are probably about 2,000 speech correctionists in this country who have at least minimal professional training. What the association would regard as highly adequate training is possessed by considerably less than a thousand of these workers. On the basis of caseload experience, and allowing for long-term success of an effective national program of speech correction, it is clear that for every speech correctionist now working there is need for about 10 or 12 more. We need, so far as we can now determine, about 20,000 speech correctionists in the United States. It does not appear likely that we will come within hailing distance of this number for at least another generation. Alert high-school seniors can find in speech correction an exciting frontier where they will find as much challenge and glamour as they are likely to come upon anywhere in the world of human work.

Articulatory disorders are the most common of the speech defects. They make up 70 to 85 percent of the problems among public-school speech-correction cases. One particular sound, the "s," is especially troublesome; nearly half of the children who have articulatory difficulties have a defective "s" sound. Whether it is the "s" or some other sound that is involved, an articulatory defect consists in omission of the sound as in "pay" for "play," or substitution of one sound for another as in "thun" for "sun," or a distortion of the sound as in the case of the whistling "s" or a slighted "l." Once the child reaches school age, and particularly after he completes the first grade, expectation that his speech-sound formation errors will correct themselves without special training is not great. After the fourth grade, very little improvement occurs without special remedial instruction. If you would like to know whether such speech difficulties are of any importance, your question would probably best be answered if you had to address an assembly, speaking with a pronounced "s" lisp, substituting the voiceless "th" for the "s" sound as in "thoup" for "soup." If you would do this consistently during a 20-minute speech you would probably never again have any reason to doubt the handicapping and demoralizing significance of even such a simple speech disorder.

Different causes, different remedial care

Among the more important disorders of voice are harshness, hoarseness, breathiness, and excessive nasality. Also, the sound of the voice can be too loud or too soft; the pitch level can be too high or too low; the rate of speech can be too fast or too slow; and the voice can be monotonous.

Now, these articulation and voice disorders can be found by themselves, so to speak, in the absence of any physical or organic abnormalities. In the vast majority of articulatory cases there is nothing physically at fault. In children who do have some kind of physical impairment, such as those with cleft palate or cerebral palsy, speech is affected mainly with respect to voice and articulation. Moreover, the kinds of voice and articulation problems that such children have are essentially the same as the kinds that are found in children who do not have physical impairments. The methods of remedial instruction used in the two kinds of cases, however, are necessarily different in certain respects. The child who does not have a cleft palate can go at the job of correcting an articulatory error by using methods that would not be possible for a child with a cleft palate.

Besides disorders of voice and articulation, there is one further basic type of speech defect: disturbance in the fluency or rhythm of speech. Disturbed speech rhythm is to be found in various forms, and it is important that these be kept distinct. In some cases of cerebral palsy, for example, the speech is slow, labored, and jerky. This is an example of disturbed speech rhythm due to basic organic cause. In some cases of brain damage, speech may be blocked rather badly or it may be mechanically repetitive. In certain psychiatric cases there is a kind of blocked utterance. There are also normal speakers who talk very fast and stumble over themselves, so to speak. Their speech is somewhat jerky and indecisive at times.

Quite different from all these is the disturbance in speech rhythm that we call stuttering. Some people call it stammering, but nowadays speech correction workers regard these two words as synonyms, and they prefer the word stuttering. Since 1925 probably few human disorders have been studied scientifically any more thoroughly than stuttering. It has been investigated in the laboratory by means of brain-wave analysis, personality tests of various kinds, biochemical analysis, measures of motor coordination, tests of intelligence, and elaborate methods of case study. The upshot of all this scientific investigation to date would seem to be that apparently stutterers are not only physically normal, but also, in any sense that would interest a psychiatrist, they are psychologically normal.

In most cases that have been studied early and in meticulous detail, the story seems to be that a child speaking with a normal number of hesitations and repetitions has come to be worried about by his parents—occasionally his teachers.

The average child between the ages of 2 and 5 years repeats a sound, a word, or a phrase about 45 times per 1,000 running words in spontaneous speech. In some the frequency extends up to about 100 times per 1,000 words, and all children do some repeating. To some fathers and mothers this sounds abnormal; others ignore it completely or don't even hear it. The parent who regards it as abnormal tends to worry about it and to worry the child about it. They do this by facial expressions, by postural tensions, by tone of voice, or by actually calling the nonfluencies to the child's attention, asking him to stop and start over, to take his time, to take a breath, and so forth. Sooner or later the child reacts to all this concern by speaking less and by doing the speaking he does more hesitantly, more self-consciously, and with decreased confidence. This intensifies the parental concern and the parents redouble their efforts to be "helpful."

Speaking should be fun

As the child tries harder to do better, effort and tension appear, blocking his speech all the more. Parental anxiety increases still more accordingly, and the child tries still harder to do still better, generates more tension, and loses more confidence into the bargain—and so the vicious circle proceeds. In general, stuttering seems to be caused mainly, in a great majority of cases, by parental anxieties concerning the normal imperfections of childhood speech—and by the elaborate train of consequences that such anxieties tend to set in motion. Once started, stuttering can be aggravated by any and all factors that tend to make for maladjustment and lowered efficiency—and these in turn tend to be aggravated by the stuttering itself.

Parents and teachers can help stuttering children most by doing nothing to make them lose confidence in their ability to speak acceptably. It is best, of course, never to call their attention in disapproving ways to the normal imperfections in their speech in the first place. Speaking should be fun—even the hesitant, unclear speaking done by normal children. Once tensions and fears in the child's speech have been brought about, everything possible should be done to remove them. The child should be encouraged to talk, he should be listened to attentively, and what he has to say and the way he has to say it should be thoroughly enjoyed by his parents and teachers. The child should be respected and loved generally. Such treatment will turn out to be as beneficial for the parents as it is for the child—for it is very good for us to do what we should do in order to help children accept themselves wholesomely and develop confidence and a sense of security.

Everyone interested in schools and in children should never for a moment set aside this basic consideration, previously mentioned, with regard to the speech-handicapped: That the schools simply have nothing else to offer them which can begin to compare in importance with effective speech correction.

Speech correction is work that requires special training. This is true, of course, of any work that is done with handicapped children. One of the most serious aspects of the problem today is that speech correction is a relatively new field; and many school administrators do not yet understand that the kind of special training required of the speech-correction teacher is quite different from that required of classroom teachers, including classroom teachers of speech. In the interests of the handicapped children concerned, the American Speech and Hearing Association should be called upon for information concerning the nature of professional qualifications in this field. (The officers of the American Speech and Hearing Association may be reached at this address: The Speech Correction Fund, Tenth Floor, 11 South LaSalle Street, Chicago, Ill.)

Over half of the 48 States now have some kind of legislation that recognizes the special needs of speech-handicapped school children. These laws, now on the books, need to be more fully activated, and laws need to be enacted in States that do not now have them. But before laws can be passed or made effective, there must be sufficient interest and determination on the part of enough people. If you are a teacher or a worker in any other field concerning children, or if you are the parent of a speech-handicapped child, or if you are an adult with a speech defect and understand the problem that speech-defective children face, or if you are a public-spirited individual who does not like to see neglect and unnecessary hardship, you have some things to say to your school board, to your school principal or superintendent, and also to your legislative representatives.

WHAT are the best methods for testing elementary-school children's sight so that those with poor vision may be referred for care? Who can give the tests most successfully? And are these procedures reliable for testing the sight of younger children? These are questions, among many other important ones, that public-health workers and educators are asking. And these are the three of basic importance that the St. Louis study of vision testing has been set up to answer. Finding the answers to these is as much as can be undertaken in a single study.

A study of vision testing recommended

The study began after a group of leaders in the field of health services for children of school age were called together in June 1947 by the National Society for the Prevention of Blindness and the Children's Bureau of the Federal Security Agency. This group met to consider what might be done to evaluate the various procedures for testing the vision of school children, and it unanimously recommended that a special study be made for this purpose. It also made helpful suggestions on how the study should be conducted.

St. Louis schools selected for the study

Upon this recommendation, such a study was set up in the St. Louis public schools, sponsored by the National Society for the Prevention of Blindness, the Missouri Division of Health, and the Children's Bureau. St. Louis was selected as the place for the study because cooperation was offered by the St. Louis Board of Education and the Department of Ophthalmology of the Washington University Medical School.

The program in the schools was begun in February 1948 and was completed in May 1949. The data are now being analyzed and interpreted, and we

WE STUDY TESTING OF CHILDREN'S EYESIGHT

MARIAN M. CRANE, M. D., Assistant Chief, Child Development Research Branch, Division of Research, Children's Bureau

After we have the results of the St. Louis vision-testing study, we shall know much more about which tests of eyesight are most suitable for use with children of elementary-school age.

expect to have some conclusions by late in 1950.

In an ideal health program for children of school age every child's eyes would receive a complete examination by an eye specialist. Because in most schools this is not possible, a screening procedure must be set up to select the children who need such an examination. Any screening method is a rough test and cannot be 100 percent perfect, but a good screening procedure is one that selects the greatest proportion of the children who need medical observation or treatment of their eyes, including especially children with serious defects, and the smallest proportion of those who do not need such care. A good screening procedure is also one that can be carried out within a reasonable amount of time and that does not require extensive training for the tester.

Various vision-testing methods in use

The Snellen chart has long been in use as a screening device. In the form of the Illiterate E chart it can be used for testing children in kindergarten and first grade. The most frequent criticism of it is that, as ordinarily used, it tests only one function, far-visual acuity. Often it is used incorrectly by persons who do not appreciate the need (1) to have an accurately constructed chart; (2) to have correct illumination; (3) to maintain the 20-foot distance; (4) to prevent giving the children opportunities to memorize the test lines, and (5) to encourage each child to read as far as he can. There are differences in the standards according to which a child is referred to an eye specialist.

The Massachusetts Vision Test was developed in an effort to devise a simple screening procedure that would find children with certain eye defects that might not be detected by testing with the Snellen chart alone. The procedure includes a test with the Snellen Illiterate E chart for ability to see distant objects clearly, and tests for far-sightedness and for imbalance of the eye muscles. It is so designed that, for each part of the procedure, performance is tested only at the critical point, and the results are recorded in terms of passing or failing. The critical point for each test has had to be set arbitrarily, on the basis of expert opinion, because there are no established criteria for what is, or is not, satisfactory performance with relation to each function. It is perhaps inevitable that some authorities question the points at which these tests make the break between satisfactory and unsatisfactory performance.

The Keystone Telebinocular Test differs in several respects from the tests that use the Snellen chart. The Telebinocular provides a series of test slides or targets, which the subject views through a specially designed stereoscope in which lenses create the theoretical equivalent of distance. Vision in one eye is tested with the other eye open, a technique that is claimed to give a better test of "usable vision" than procedures in which the other eye is closed. Targets are provided for tests of far and near visual acuity and muscle balance, and for tests of fusion and depth perception. The significance of some of these tests has been questioned.

Other vision-testing procedures are being used for screening the vision of school children, but these three represent the general types of testing.

Use of teachers' observations

In addition to the evidence obtained from testing procedures, valuable information about the presence or absence of eye difficulties can be obtained through observation of the child. The teacher, more than anyone else in the school, has the opportunity to see the child's behavior under various conditions. She knows his school progress and, if she is interested, can know his health history. She can often recognize children who should be referred for eye examination if she is familiar with the common signs of visual disturbance, such as frowning or squinting when looking at objects, tilting the head or thrusting it forward in an effort to see better, or holding objects closer to or further from the eyes than is normal. Health programs in different school systems vary greatly in the emphasis that they place upon the teachers' observations; the programs vary from almost complete disregard of the contribution the teacher can make to dependence on teachers' observations alone or on teachers' observations plus a test with the Snellen chart, as the basis for referral for an eye examination.

Who should do the testing?

Not only does the question arise of what vision-testing procedure should be used, but of who should do the testing. Should it be the classroom teacher, or one teacher for the entire school, or the school nurse, or a technician who does all the vision testing for a group of schools?

The amount of training that can be given the different types of testers will vary. The classroom teacher can easily learn to give a simple test, but it would not be practicable to train every teacher in more elaborate testing procedures. The school nurse, or a teacher who is selected to do all the testing for an entire school, can be given a longer training period. A special vision-testing technician, who tests the children in a group of schools, would be expected to have more training and experience than a nurse or teacher who tests in one school only.

In some programs the classroom teacher has primary responsibility for selecting the pupils who require special attention for any health condition. The teacher, because she has an intimate acquaintance with the child, may be in a better position to evaluate the child's performance in a vision test than another tester would be, and the child may do better if the test is given by the teacher, with whom he is familiar. On the other hand, some believe that school nurses, rather than teachers, should carry the responsibility for the health program.

Opinions vary, therefore, as to who should administer the vision tests in a school, but no real evaluation has been made of the relative efficiency of the different types of testers.

Should testing begin with the first grade?

There is lack of agreement also on the value of vision tests for beginning readers. It would certainly be helpful to be sure that a child can see normally before trying to teach him to read. But whether the vision-testing procedures are sufficiently reliable with young children to give dependable results is questioned. If they are not reliable, a vision-testing program for children entering the first grade is a waste of time and may give misleading results.

To find out whether a screening procedure is successful we must compare its results with a standard. The standard for the success of screening tests for eyesight is the decision of the ophthalmologist as to whether or not the children selected do need observation or treatment because of any condition related to their eyes.

One of the difficulties in evaluating vision-testing procedures has always been that no definitions have been established of the smallest degree of abnormality of the eye for which observation or treatment is needed. The many factors that can be involved in a diagnosis of an eye condition make it very difficult to set up any such definitions; the decision regarding treatment is based upon clinical judgment, which takes into account the various factors involved in the individual case. In borderline cases one eye specialist's decision as to whether treatment should be given may differ from that of another.

In the present study, in order that the clinical judgments with which the results of testing procedures are compared may be accepted as a reliable standard, the following plan was adopted: The results of the screening procedures are compared with the findings of clinical examinations given in a medical school department of ophthalmology of recognized standing in its field. The examinations are given by a small number of ophthalmologists, each giving one part of the examination to all of the subjects, so that the procedures followed are uniform. All clinical judgments as to whether the findings indicate need for observation or treatment are given by one ophthalmologist in this group. An advisory committee made up of outstanding specialists in ophthalmology works with this ophthalmologist to establish, insofar as possible, definite criteria upon which the clinical judgment is based.

The screening procedures being evaluated in the study are the following: A teacher's report of symptoms observed and of whether, in her opinion, the child needs to be referred for an eye examination; a test with the Snellen chart; the Massachusetts Vision Test; the Keystone Telebinocular Test; the American Optical Co.'s Sight-Screener Test, and the Bausch and Lomb Ortho-Rater Test.

The last two screening devices have been developed primarily for use in industry and have not been adapted for use with children. But because they are being rather widely used and might be made suitable for school use, it seemed wise to include them in the study. Both use stereoscopes through which the subject views test targets, but there are certain important differences between them, and between each of them and the Telebinocular Test.

We include a test for near vision

In addition to these procedures, a simple test of near vision was given. Opinions differ as to the value of any test of near vision for children. Some say that because a child is expected to use books in his school work, it is important to test his vision at the near point. Others say that, even though he may have a considerable degree of farsightedness, a child has such powers of accommodation that he will be able to focus on a near-point test chart long enough to pass the test satisfactorily, even though he could not read at that distance for any length of time without discomfort. It is hoped that including such a test in the study will help to answer the question of its value.

The children who were tested

The children whose vision was tested were pupils in the St. Louis public schools in the first and sixth grades. We studied pupils in only two grades so as to have large groups of children of approximately the same age, and to eliminate the variations that might be due to differences in age. The sixth grade was selected because pupils of that age can give full cooperation. The first-grade children were studied to determine whether the tests are reliable for young children. In the 14 schools in which the study was conducted, all first- and sixth-grade students were tested except those whose parents refused permission for the clinical examination. The children tested—about 600 in each age group—will, it is hoped, have provided enough data for reliable statistical analysis. The Ortho-Rater and Sight-Screener Tests were administered only to sixth-grade children because the test targets of these tests are not suited to children who cannot read.

Three types of testers

In order to obtain information as to who can administer the tests successfully, three types of testers were used: (1) The teacher, who reported her observations on the children in her own class and gave them the Snellen Test: (2) the school nurse for each school, who gave all the children in that school the Telebinocular, the Sight Screener, the Ortho-Rater, the near-vision, and the Massachusetts Vision Test (the Massachusetts Vision Test includes a Snellen Test); (3) one technician, who tested all the children included in the study, giving the same tests that the nurses gave.

Each child was tested by each of the three testers, and each tester gave to each child the entire series of tests for which he was responsible. Thus every first-grade pupil received 7 tests and every sixth-grade student 11 tests. In addition, every child was given a complete ophthalmological examination, with the pupils of his eyes dilated by drops.

Each test was given according to the procedure recommended by those who developed it. Before the testing program was started there was a training period for the study personnel. For each test, except the Snellen and near-vision tests, a member of the group that developed the test spent about 2 days with the staff, demonstrating the procedure to be followed. Special training was given to the technician chosen for the study and to a school nurse assigned full time to the work, to whom the title of "nurse-coordinator" was given.

Before we began the testing program in an individual school, the nurse-coordinator spent a week training the school nurse in the testing procedures and instructing the teachers of the first and sixth grades in administering the Snellen test and in recording observations. A prescribed plan of training was followed, so that each nurse received exactly the same instruction. Uniform instruction was also given to the teachers. Pupils from classrooms other than the first and sixth grades served as practice subjects.

Randomization of testing sequence

The possibility that the experience of having one test might influence a child's performance when he was later given another test made it necessary to randomize the order in which the pupils went to the different testers and the order in which a tester administered the different tests. Half the children were examined by the ophthalmologists before the battery of tests was given; the other half received the screening tests first and the clinical examination later. For first-grade children there were 24 possible sequences of tests and testers; for sixth-grade children the greater number of tests increased the possible combinations.

What will the study show?

By comparing the results of the vision-screening procedures with the judgment of the ophthalmologist as to whether or not the child's eyes need observation or treatment, we hope to determine, as described earlier in this paper, which procedures fulfill the first requirement of a good screening test, that of selecting the largest proportion of the children who need be referred for care and the smallest proportion of those who do not need to be referred. By comparing the results of the tests administered by the different testers, we should learn something about who can do the testing successfully.

The data collected in this study of vision-testing procedure will probably be suitable for various types of analysis. These analyses may give valuable additional information regarding the eyes of children and about vision-testing techniques. But the primary purpose of the study is to evaluate the different procedures in terms of their usefulness for programs for the health of children of school age.

Individual children served

The program conducted in St. Louis was a service program for the children whose eyes were tested, as well as a scientific investigation. If the clinical examination showed that the child's eyes required observation or treatment, this information was given to the school nurse.

The Division of Health and Hygiene in the St. Louis public schools welcomed the opportunity to act on this information through its program for referral and follow-up of children in need of medical care. The division has available certain funds provided by private organizations for the purchase of glasses for children who need but cannot afford them. The nurses have interviewed the parents of children who needed treatment, and their reports show that they have been successful in getting the children placed under the care of eye specialists.

The study was not set up as a demonstration program. A plan that calls for 11 tests and a complete ophthalmological examination for each child would not be practicable for general use. But from the analysis of the data obtained we hope to get information that will be helpful in planning vision-screening programs.

Thanks due St. Louis public schools

A tribute is due to the St. Louis public schools for their cooperation in this study. The staff of the administrative and health divisions contributed to the planning and arranged for the teachers and other school people to take part. School principals, teachers, and nurses gave generously of their time. Their explanation of the project to children and their parents resulted in excellent cooperation from both.

If the study in St. Louis produces the information we need in order to plan better vision-testing programs, the children of the whole country will benefit from this work in a single city.

SO THAT CHILDREN MAY HEAR BETTER

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A HEALTH PROGRAM for children of school age should do everything possible to detect hearing impairments as early as possible, and any child with a hearing defect should be seen promptly by an ear specialist. It is not always possible to restore perfect hearing, but often the progress of the condition may be stopped by prompt medical attention. Impairment of hearing is frequently accompanied by emotional and educational difficulties that are the natural consequence when a boy or girl does not hear well.

Fortunately, it is now possible to attack problems of hearing impairment with reasonable assurance of success. We now have adequate techniques for detecting impairment, new methods for diagnostic testing, the benefits of recent advancements in medical therapy, and fresh insight into the development of compensatory language skills.

Although our use of language is conditioned by a variety of factors, our hearing mechanism is the natural channel through which we learn to talk. We talk because we hear and as we hear. When a child's hearing is profoundly impaired, he can learn to talk only after long and painstaking special education. Short of profound hearing impairment, however, there are many lesser degrees of hearing disability that interfere with the development of normal speech habits and that usually prevent the child from developing and behaving normally.

The damaged hearing mechanism is only part of the picture; in terms of language development and social maturity, the basic difficulty is that the child is unable to exchange ideas with others or to take his full part in the activities of the classroom, the playground, and the home. That is why, if a child's ears are put in as good repair as medical science can achieve and he still has a hearing disability, we must center our attention on the psychological, social, and educational aspects of helping him to communicate with others. Not just his ears, but the child as a whole, is the focus of our attention. In a health program in school, this means that a number of professional services are needed in order to recognize and meet each child's individual needs.

Several facts relating to hearing impairment warrant careful consideration by everybody concerned with the health and welfare of school children. Some of these facts are:

1. We have good evidence that about 5 percent of the school children in the United States have impaired hearing.

2. Few school children have their hearing tested regularly (a recent national survey puts the figure at 11 percent).

3. Many children's hearing impairments can be cured or minimized by early diagnosis and treatment.

Principles that underlie the school's hearing program are:

1. Good hearing in as many of the children as possible is the fundamental objective.

2. When we find that it is impossible to remedy a child's hearing impairment, we must emphasize prevention of the undesirable habits, attitudes, and behavior that often accompany such impairment.

3. A school hearing program does not focus merely on a child's hearing, but on the child as a whole.

4. If a permanent hearing impairment still exists after the child's ears have been treated, the problem centers about increasing the child's ability to communicate with others.

5. The foundation of a good program is finding and diagnosing the child with impaired hearing. Special education should be started only after the impairment is reduced to a minimum and the nature of the remaining impairment is carefully evaluated by a specialist.

These facts and principles point up the need for a cooperative program wherein both health and educational services are available for the needs of the children.

Audiometry is the most accurate means for measuring hearing. It includes tests that measure the hearing of pure tones and of speech.

In pure-tone tests, a series of tones (usually 9 or 10, across a range of 6 to 7 octaves) are sounded in order to determine the child's threshold of hearing (the point of least loudness at which he consistently hears each tone). This point for each tone is recorded for each ear, and the result is graphed as an audiogram, such as those on pages 20–21. The shape of this pattern gives much useful diagnostic information.

When we test a child's ability to hear speech, we find that we can get much additional information that is essential in diagnosis. Moreover, because speech-hearing tests reflect the level at which the child lives with his impairment, this information is even more important in analyzing the nature and extent of the communicative disorder and in deciding what training is best for the child's welfare.

How well does he use his hearing?

There are two significant aspects of speech-hearing testing: (1) The measurement of threshold, by definition the loudness level at which the child distinguishes 50 percent of what is said to him; (2) the measurement of his ability to discriminate fine differences among speech sounds under conditions of ideal loudness. Both of these tests can be done fairly well with the use of the microphonic circuit that is included in many commercial audiometers; for precise results, special equipment should be used in a soundproofed room.

Pure-tone audiometry tells us what the child *cannot* hear—that is, he cannot hear the test tones at a loudness level that is lower than his threshold. But speech-hearing audiometry tells us how well he uses his hearing in active communication. This knowledge is essential if we are to recognize the child's language shortcomings and to know what we can do to help him to overcome them.

The findings of pure-tone tests and of speech-hearing tests given to an 8-year-old boy with normal hearing, Bill, are recorded in the first audiogram on page 20 (fig. 1).

Hearing impairments, as we stated before, take several forms, and each has several degrees of severity. When the middle ear is damaged, conduction of sound may be blocked, and thus conversation and noise are reduced in loudness before they reach the inner ear. When the inner ear—the perceptive mechanism—is damaged, sounds are not only diminished but distorted.

Ordinary speech sounds have a tonal range from approximately middle C to the C that is four octaves above; if a child is to hear speech well he must be able to hear sounds over this range. If the child's hearing nerve is impaired he may hear the lower tones fairly well without being able to distinguish clearly sounds of ordinary speech in the middle and upper tones. He hears distorted sounds, and the result is conversational confusion. The problem then is not merely hearing versus deafness. It is necessary to find out accurately how much difficulty the child's loss of hearing is causing him in communicating with other people.

Thorough audiometric screening will reveal many youngsters with mild to moderate hearing loss that is related to acute or chronic upper-respiratory conditions. These infections can usually be treated successfully, and the child's hearing is usually improved considerably, or even restored to normal.

Figure 2a illustrates such a case, in 6-year-old Bobby. The upper audiogram shows he had a moderate hearing loss of conductive type (38 decibels), caused by upper-respiratory infection, but no trouble in understanding speech if it was loud enough. Bobby had, however, some difficulty with ordinary quiet conversation and considerable difficulty in the classroom. The second audiogram (fig. 2b), made about 9 months later, after Bobby was treated for the respiratory infection, shows how much the child's hearing had improved. His speech-hearing threshold had risen to 8 decibels, a level that is not significantly below normal.

It is often impossible, however, to improve a child's hearing in such cases unless his impairment is diagnosed and treated early. Therefore, early discovery and treatment of such children should constitute a major part of audiology in schools. These children need not only prompt medical attention, but also careful supervision by both teacher and parents while the medical treatment is being carried out. The teacher may need to change the child's classroom seat so as to enable him to work to the best advantage. She should take care that he follows group discussions and should keep a watchful eye on his progress. Giving the child some training in speech reading (a more accurate term than lip reading) is often advisable as a precautionary measure.

Once it has been established that a child has a permanent hearing loss, we have good reason to think about the type and degree of his disability, about its effect on the child's behavior in general, and on his ability to communicate with others. His needs will vary greatly according to whether the loss is marginal, moderate, severe, or profound, and according to whether the impairment appeared before or after his language pattern developed.

Many children have a slight to moderate impairment, with more than one cause. Injury to the mechanism that conducts sounds frequently responds to treatment, but injury to the perceptive element cannot be remedied. In either case, the educational procedures to be followed should be governed by the findings of the otologist and the audiologist. If the child's permanent loss of hearing does not exceed 35 decibels, it may suffice to teach him speech reading and to seat him in his classes so that he can hear as well as possible.

A typical example of this kind of problem is shown in figure 3, which is an audiogram of a boy of 7, James. He was brought to an audiologic center by his parents because an alert second-grade teacher had noted an apparent difficulty in hearing in the classroom and had advised a check. The parents had been completely unaware of any difficulty. This is not unusual when a child has only a mild loss of hearing. The boy's speech hearing is at a 28-decibel level, which may improve to some extent as the conductive element responds to treatment.

If the loss exceeds 35 decibels, the child should, in addition, be given a carefully selected hearing aid and should be trained in its use. Speech correction or speech training may be needed for certain children whose hearing loss is sufficient to interfere with their developing or retaining certain speech sounds.

Chronic upper-respiratory infection and earache can exact an unbelievable toll of damage to the hearing mechanism and hence to the psychosocial adjustment of the child, but persistent treatment to keep the upper-respiratory mechanism in good condition can do away with, or at least reduce, much impairment.

Figure 4 offers dramatic evidence of this in a boy of 11, Frank. The lower audiogram shows a severe impairment, which kept the child from hearing normal conversation. At the time this audiogram was made, he had sinusitis and had had a cold for a month. His hearing loss had increased progressively over a period of years until he had so much difficulty in getting along in the classroom that he was sent to a special school for children with impaired hearing. An otologist was consulted at this time, and a course of treatment begun. The upper audiogram in figure 4 was made 17 months later, when the boy was relatively free from symptoms and had essentially normal hearing. He was able to go back to his regular classroom.

By no means can all such impairments be treated so successfully. All too often chronic infection damages the hearing mechanism permanently. Most cases, however, respond to early treatment, and this emphasizes the importance of adequate diagnosis and medical care before any nonmedical procedures are begun.

Impairment of the perceptive element in hearing, which is caused by damage to the nerve cells, requires more special handling than does impairment of the conductive element, for this type of impairment results not only in reduced acuity for sound but also in reduced ability to make the necessary discrimination for speech. We must explore the child's ability to hear speech before we plan to rehabilitate him. A hearing aid may or may not be helpful. If one is used, it must be carefully selected so that it will help the child to discriminate among speech sounds. And we must train him in using his hearing aid.

The following three cases suggest the variety of problems related to a perceptive-type hearing loss.

Figure 5 is an audiogram of a boy, Hughie, with a perceptive-type loss. At the age of 8 he shows great reduction in his ability to hear high-frequency tones. His family was unaware of his hearing loss until they began to realize that his speech was unusual and that his vocabulary was slow in developing. This child is not deaf in any sense of the word, yet he cannot hear normal language well enough to reproduce it accurately; he hears but does not understand. His speech-hearing threshold for certain two-syllable words (spondaic words),

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We are here presenting audiograms, showing the results of hearing tests for seven children (figs. 2a and 2b are for the same child).

On each audiogram a child's thresholds for pure tones are shown, for each ear.

His ability to hear speech is shown by a pair of short horizontal lines extending across the range of tones covered by ordinary talking. The figure written at the right of this pair of lines shows, in decibels, how far below normal is the child's threshold for hearing speech.

Bill's audiogram (fig. 1) shows normal hearing.

Sometimes a child's hearing impairment can be remedied through treatment. His audiogram after treatment then gives evidence of improvement. Figure 2b, Bobby's second audiogram, taken 9 months after his first examination, is an example of this; another is Frank's upper audiogram (fig. 4).

James' hearing loss, as shown in figure 3, is typical of one kind of perception impairment for which there is no medical treatment.

Hughie (fig. 5) hears speech in a distorted way; some sounds he hears normally; others not at all. A hearing aid would only complicate the distortion. On the other hand, a hearing aid is helping Nettie (fig. 6) and Charles (fig. 7). For both these children, two thresholds show how much better they get along with the aid than without it.

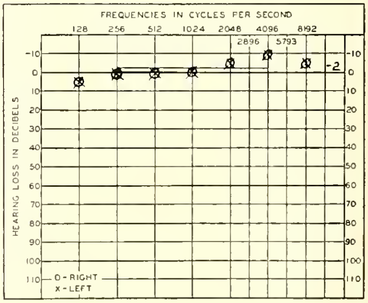

Figure 1. Bill

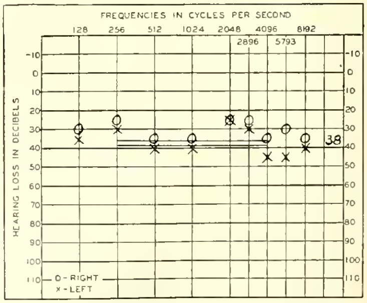

Figure 2a. Bobby at his first examination

which are selected to test low-tone response, is 8 decibels, not much below the normal range; yet his ability to recognize fine differences among consonant sounds is 30 percent below normal. A hearing aid will not help him. Speech reading will be useful to him in many situations, and he will profit to some extent from speech training.

To build a bridge for communication

The age of the child at the onset of a perceptive-type impairment, as well as the severity of his hearing loss, will greatly color the diagnostic picture as far as language facility is concerned. The language facility, in turn, will determine the basic educational procedures needed. The child whose language patterns were established before the hearing loss was incurred presents a far different problem from that of the child who has never heard well enough to develop language skills through the usual imitative channels. Where the one child has a ready communicative bridge between him and his world, no matter how severe his impairment, the other needs special education in order that some kind of bridge be built. This requires long, persistent training, at best. Intensive special work is required until the child has gained some language facility. If this training is begun at the nursery and preschool level, many of these children can be expected to do well later in regular school with the help of special tutoring. The timing will vary for each child, depending on his ability and on the educational advantages that are available.

A severe, congenital, perceptive-type hearing loss is illustrated in figure 6, the audiogram of a junior-high-school girl, Nettie. Her parents became aware of the problem when the child was slow in learning to talk. She was given a great deal of careful attention at home and in nursery school, and good language habits were established through intensive work in speech reading and early fitting with a hearing aid, coupled with work in auditory discrimination and speech training. Despite the severity of her impairment, this child has been educated in regular school, with special tutoring, and is now a good student. She is alert and well-adjusted in every way.

Figure 7 illustrates the case of Charles, 9 years old, who had an extreme, profound, congenital, perceptive-type impairment. (He is now making good progress in a special school.) The better of the two hearing thresholds represents his achievement with a hearing aid. With it he can understand vowels without speech reading; his voice is better modulated; he is aware of acoustic changes in his environment that he would otherwise lack. He will never be able to understand conversation without the hearing aid, but with a combination of visual and oral cues he can communicate quite readily. His speech is marked by distortion of the consonant sounds that he cannot hear, but it is fluent and understandable and is a useful social tool.

Although screening and much of the

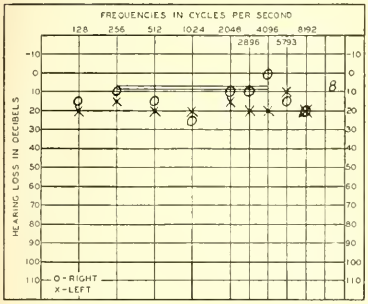

Figure 2b. Bobby, 9 months later

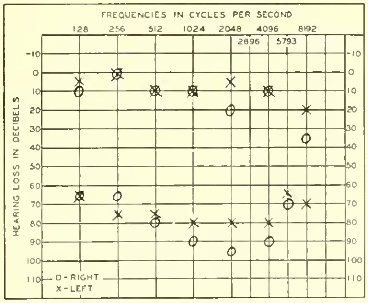

Figure 4. Frank

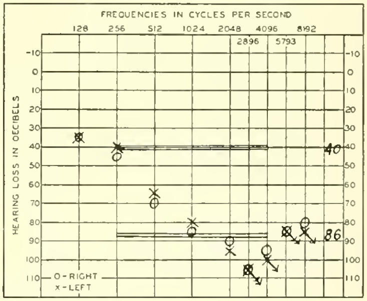

Figure 6. Nettie

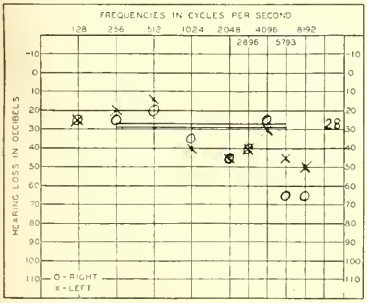

Figure 3. James

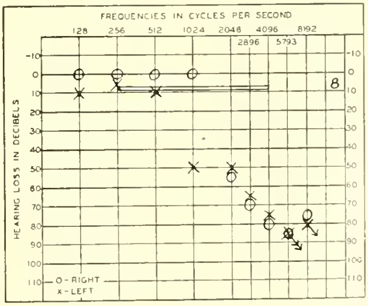

Figure 5. Hughie

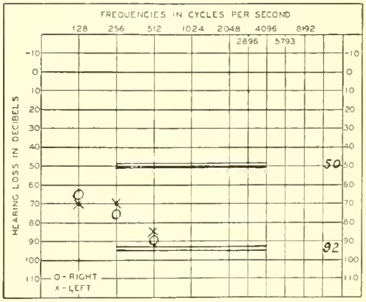

Figure 7. Charles

diagnostic testing is carried out by nonmedical specialists in audiology, diagnosis is a medical responsibility. Moreover, because the welfare of the child as a whole is concerned—not only his impaired hearing but also his general health and behavior—clinical study should be made an integral part of pediatric service in school. Regardless of the details of medical management, whether the child is under the care of a private physician or is treated in a public health service, case finding and diagnosis are best carried out as part of a unified undertaking within the framework of the health program in the school and utilizing its facilities and personnel.

Within this framework, a practical program in audiology works as follows:

1. Case finding is centered in the schools through a regular routine of screening tests administered by adequately trained professional personnel and through teacher observation.

With some types of hearing loss, we can help a child by fitting him with a hearing aid.

2. Children selected by screening techniques are retested immediately by pure-tone audiometry to determine their thresholds of hearing.

3. Children who show a significant degree of impaired hearing (in the majority of cases the impairment is mild and usually treatable) are referred to an audiologic clinic. These children receive the full battery of clinical audiologic tests, including speech tests and otologic examination.

4. The pediatric clinician is responsible for the health of the children and refers them to other agencies for whatever special diagnostic examinations they need—dental, mental hygiene, and the like.

5. Ideally, each case is "staffed" by the entire examining group, and recommendations for complete case handling are made. The school nurse follows up these recommendations with the parents and teachers concerned.

6. The necessary clinical services, medical or nonmedical, may be undertaken privately or through public health services, whichever is feasible. Long-term training and retraining (for instance, speech training and speech reading) are carried out in the school system. Consultative service through State and local departments of education is increasingly available to help in such programs.

7. Individual referrals are made by teachers on the basis of observation. The supporting diagnostic services are available at all times for referral of individual cases by the school pediatrician.

8. Referral is made for vocational guidance when necessary.

Planning for the child's welfare

A program of this sort is not an ideal in the sense that it is unachievable. On the contrary, such a planned cooperative scheme is being carried out or is in development in a number of communities. Although ostensibly expensive to establish, it proves less costly and more efficient than any haphazard service of incomplete diagnosis and inadequate follow-up, wherein a variety of specialists may work with a child without unity and often without coherence so far as the welfare of the child as a whole is concerned. For the sake of the child, as well as for behavioral, economic, and administrative reasons, every effort should be made to help the school child by means of supplementary training in the regular classroom, if the necessary compensation can be made in this way, rather than placing him in a special school that may tend to make him seem different from other children. Sometimes, however, the best interests of the child are served by placing him in a special class equipped to give him the help he needs.

The child with impaired hearing is not necessarily otherwise abnormal and must not be treated as though he were. Even the child with a severe loss in his ability to hear speech can learn to keep pace in school if his needs are known and met early enough.

Since many hearing impairments can be cured, and since permanent impairments involve the communicative habits, the development, the general behavior, and the social maturity of the child, his parents should team up with a number of professional workers to maintain his health and welfare. This team should include (besides the parents) the teacher, nurse, pediatrician, otologist, audiologist, psychologist, vocational-guidance counselor, speech correctionists, and whoever else is useful.

This is much more than an effort to conserve hearing; it is a joining for that purpose of school and health authorities, of parent-teacher groups, and of everyone else who is in contact with our children of school age.

ENCOURAGING GOOD FOOD HABITS IN SCHOOL-AGE CHILDREN

E. NEIGE TODHUNTER, *Head, Department of Foods and Nutrition, University of Alabama*

ALL who work with children have their dreams of the future. The nutritionist dreams of alert, vigorous children who joyfully eat enough of all the foods they need: children who, when they eat in a cafeteria, naturally choose milk, fruits, and vegetables, along with some meat and eggs; and families where never is heard a disturbing word at meals, such as "I don't like it" or "I don't want any."

That day has not yet come, but the goal is not an impossible one. It is a goal that we know is worth while and is possible of achievement. The importance of food as a major factor in determining growth and vigor and physical, mental, and social well-being has now been well-established through clinical and laboratory evidence. Our knowledge is on a sound foundation.

Nutrition is a comparatively new science. The ways in which foods differ in their nutritive value are now generally understood; but such knowledge has not yet reached all parents or all professional workers for children. Too often the influence of nutrition is overlooked because the ill effects of poor eating habits, begun in early childhood, may not become apparent for a number of years.

Human beings do not long retain any instinct concerning the foods that are essential for their normal growth and development. The well-known "self-selection" experiments of Dr. Clara Davis in 1929 do not contradict this statement. Dr. Davis found that when young children were offered a wide variety of natural foods, such as fresh fruits and vegetables, eggs, meats, milk, whole-grain cereals, and butter, they selected meals that met their needs for normal growth and development. Unfortunately, these favorable conditions for self-selection of food are not often encountered by children. Adult rules and prohibitions, access to sweet foods, and the influence of radio and colorful advertising soon begin to establish a pattern of likes and dislikes for the young child.

Research finds poor dietary habits

The Research Laboratory of Human Nutrition of the University of Alabama is engaged in study of the nutrition of children in three schools. The research workers have found such conditions as poor dietary habits, with low intake of milk, fruits, and green vegetables; frequent omission of breakfast and supper; and eating between meals, particularly candy and soft drinks. In one-fifth of the children these findings about food habits were accompanied by a physician's rating of physical signs of poor nutrition. And the dentist who examined the children's teeth found that two-thirds of the children needed dental attention. These findings are in agreement with those of investigators in other parts of the country.

We now know that the mother's diet during pregnancy is a major factor in determining the health of the child at birth. Studies at Harvard School of Public Health have presented convincing evidence of this.

The next step forward is to act on the principle: "Every child has a right to know what he should eat." In the schools we have an opportunity to provide children with the information and the experiences through which every child may acquire good eating habits. Habits are acquired more easily at an early age, and therefore such training should begin in the lower grades. The following nutritional goals are proposed here as desirable for all who work with children; they are goals that may more readily be attained through the school-lunch program.

1. To develop in children a liking for

a wide variety of foods so that they will enjoy eating the foods that are essential for their growth and development.

2. To help them learn regular habits of eating, sleep, rest, fresh air, and exercise.

3. To develop in them an understanding that the kinds of food that they eat do influence growth and health.

4. To teach them to recognize that sweets and desserts add zest to a meal but that they should be used in moderation and only after all their other food needs are met.

5. To influence them so as to make the preparing and eating of food a joyous occasion as well as a means of attaining health.

6. To help them to separate food habits from moral values and rewards, and to get rid of the idea that certain foods are "good for you," or that a child is "good" because he eats some particular food and "bad" if he refuses it.

7. To teach children to *practice* good nutrition rather than just to know many facts about foods.

8. To gain the interest and cooperation of parents so that their children may carry nutrition knowledge and desirable food habits back into the home.

What is a good noon meal?

Many children have been found to start the day without breakfast, or with a breakfast that is inadequate in kind and amount of food. In order that children may carry on throughout the day and avoid fatigue and listlessness, and quarrelsomeness and disturbances, it is imperative that they get a good noon meal.

For every child, lunch should provide a meal that is nutritionally adequate: that is to say, it should supply at least one-third, and preferably more, of the child's nutritive requirements for the day. A basic pattern for such a meal is:

One-half pint of milk to drink;

Two ounces of meat, fish, poultry, or cheese, or an egg, or 4 level tablespoonfuls of peanut butter, or one-half cup cooked dried peas or beans;

Three-fourths of a cup of vegetable or fruit, or a combination of these;

One or more servings of bread, muffins, biscuits, or other breadstuff;

Two teaspoonfuls of butter or of margarine fortified with vitamin A.

Such a meal pattern provides for nutritional adequacy. It also allows for wide variety in choice of food and method of preparation, as well as being adapted to regional differences in food habits. The meal selected from these foods can be prepared as a hot meal for cold winter days, or as an attractive cold plate for warmer weather, or as a packed lunch to carry to school or to work. It is a pattern that can be used at upper-income levels and also where there is comparatively little money to spend for food. This is a food plan that is basically sound for all children, whether at home, at school, or in an institution.

School lunch contributes to health

With the realization of the need for better feeding of children, the Research Laboratory of Human Nutrition at our university has for the past 11 years devoted a considerable part of its time and resources to a school-lunch program. This program was chosen as the avenue for nutrition work for several reasons:

(*a*) The school-lunch program provides the opportunity for direct work with large numbers of children;

(*b*) Children, particularly in the lower grades, have established fewer undesirable food habits that need to be changed than adults have, and they are receptive to new ideas;

(*c*) A child carries home many of the ideas and practices that he has learned at school, and thus we have an opportunity through this program to influence, at least indirectly, the whole family;

(*d*) A child needs to know the reasons why he should eat certain foods so that he can take responsibility for his own health; the school lunch gives opportunity to integrate nutrition teaching, not only as part of the health program, but also as part of the total educational program for the development of the whole child;

(*e*) The school lunch gives opportunity for many individuals and agencies to work together for the welfare of children; in fact, it is essential that they work together if success is to be achieved.

The school-lunch program has spread throughout the country because of the recognition of the part that nutrition plays in the welfare of children. This program is designed not just as a means of feeding hungry children or of using up agricultural abundances. It is planned to be an integral part of the total school program and to make it possible for every child to have an adequate lunch served at school.

Federal aid through the National School Lunch Act has made it possible for many schools to start such programs when otherwise they would have been financially unable to do so. But whether a school receives Federal aid or not, the fundamental principles for operation of a school-lunch program remain the same.

The school-lunch program is built on the basic noon-meal pattern described previously. The main concern of the school-lunch program is not whether a hot lunch is served but

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Lunch should supply a third or even more of the nutritive requirements for the child's day.

A PEDIATRIC CLINIC SERVES CHILDREN OF SCHOOL AGE

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WHEN I joined the West Virginia State Department of Health early in 1947 as pediatric consultant, it was with the understanding that I should devote most of my time to the consideration of the health of school-age children. I was delighted with the prospect, first, because for some time it had seemed to me, through observations made in my private practice, that health problems of school-age children are frequently overlooked or underestimated by parents (and sometimes by physicians as well); and secondly, because in most places school health services are unquestionably inadequate. It was the latter situation that I hoped to study in an effort to bring about improvement. It is probable that if this second condition could be righted, the first one might be corrected through gradual education of the children's parents.

We choose a county

Health services in schools throughout our State are rather poor. There is no coordinated program on a State-wide basis. In 14 counties a total of 37 nurses are employed full time by county boards of education to work in schools. In 36 counties the board of education pays the salaries of public-health nurses who do nursing in schools as part of a generalized program, or contributes to their salaries. Only 1 county, Kanawha, has a full-time school physician. In most of the other counties the job of supervising programs for the health of school children falls to the lot of the county health officer, if there is one. In our efforts to improve health services for children of school age we felt that it would be desirable to work with a unit whose services already were nearly complete. In line with this idea, we selected Kanawha County because it had a full-time school physician and 14 full-time school nurses.

During conferences we had with the physician for the Kanawha County schools, we conceived the idea of establishing a school diagnostic and treatment clinic. The necessity for such a clinic was pointed out by this doctor, who said that the greatest problem was how to get follow-up care for children in the schools. The children's health problems were screened by means of teacher-nurse conferences in the schools, and immunization procedures were properly carried out, along with other measures to control communicable disease. However, beyond obtaining certain types of services for the correction of remedial defects—eyeglasses, hearing aids, orthopedic care—through voluntary organizations and State crippled children's services, the school physician and nurse were helpless; they could do no more than point out abnormalities to parents and recommend medical attention. Needless to say, many parents or guardians, either because of financial limitations or because they did not recognize the child's true needs, had never acted on these recommendations.

Clinic space, time, and staff

Having arrived at the idea for the clinic, we were confronted with finding a place for it. None of the schools had space or facilities for establishing such a clinic. Besides, we wanted the clinic to be as centrally located as possible so as to make attending it equally convenient for all. By conferring with the director of the Kanawha-Charleston Health Department, we found that suitable space and facilities were available at the health department. In fact, we could use rooms that had just recently been attractively decorated for the use of another clinic. Because the other clinic met only 1 day a month, it was easy to arrange a different time for ours.

We decided to hold our clinic twice a month—on the first and third Wednesdays, from 12:30 to 3:30 p. m. We chose arbitrarily to see only six patients at each clinic session in order to have enough time for physical examinations, for laboratory work, and for consultation with both the social worker and the nutritionist that we were planning to have there. The 2-week interval between clinic sessions would allow adequate time for the clinician to obtain the laboratory reports necessary to aid him in making a diagnosis. And 2 weeks is not too long to allow between visits.

For the first 15 months six pediatricians took part in the clinic. These doctors are all qualified practicing pediatricians, who had expressed a desire to work with a clinic of this type. For the first 15 months they rotated their services in the clinic, each one serving for a month at a time, at two consecutive clinic sessions. Since July 1, 1950, the full-time pediatric consultant on the staff of the maternal and child-health division of the State department of health has been the clinician.

Patients are referred to the pediatric clinic by the health service in a school, by private physicians, by social-welfare agencies, by county public-health nurses, and by well-child conferences. Any child who is referred to the clinic is accepted for an initial visit. He is given an examination that includes a complete series of laboratory tests as well as consultation with the nutritionist and, when necessary, the medical social worker. If a diagnosis cannot be made with certainty at the time of the first visit, the child is asked to return for a second. After that, if we think that the family can afford the services of a private physician, we may ask the parents to take their child back to him. If they do not have a family physician, we may give them a list from which they may choose.

In most instances we refer the child to other clinics of the health department for special services or diagnostic work, but he returns at intervals to the pediatric clinic for general health supervision. Whenever necessary, home visits for follow-up care and instruction are made by the public-health nurses. When there are social or emotional difficulties that affect the health of the child, the medical social worker carries responsibility for helping the family to deal with such problems. Some services that are required are not obtainable from a private practitioner; for example, the advice and guidance our nutritionist gives in the clinic. When malnutrition caused by poor dietary habits seems to be the chief problem, the patient is asked to continue at the clinic for follow-up visits with the nutritionist, regardless of his family's financial status. Another service that is obtainable locally only through a public-health agency is electroencephalographic readings, which are done in the mental-hygiene clinic of the health department. However, a charge is made for these readings if the patient is able to pay.

Other agencies work with us

In order to obtain complete diagnostic and therapeutic services, we work in close cooperation with other clinics or agencies; for example, (1) an orthopedic clinic, which is part of the State crippled children's program; (2) a cerebral-palsy clinic, which is run by the State society for crippled children and the local health department; and (3) the cardiac clinic of the local health department. We also work closely with specialists in private practice. Tonsillectomies are done by a qualified otorhinolaryngologist at the Salvation Army Hospital. Children who have diabetes are referred to the diabetic out-patient clinic at the Charleston General Hospital; behavior problems are referred to the mental-hygiene clinic. In addition, allergy tests, when needed, are made by one of the city's leading internists in his own office, and X-ray therapy is given by a roentgenologist in his laboratory. These services may be paid for from State maternal and child health funds. A list of the clinics, agencies, and individual practitioners to whom children may be referred is posted in the clinic for the convenience of the clinician.

Routine medications such as iron or vitamins are dispensed from the city-county pharmacy in the same building as the clinic; and those of an unusual nature may be obtained from one of the local pharmacies at the expense of the clinic, with a prescription issued by the clinic. A list of all the drugs carried in the city-county pharmacy is posted in the clinic's examining room.

Examination is comprehensive

Routine laboratory procedures are carried out for each patient who comes to the clinic and include complete blood count, urinalysis, sedimentation rate, tuberculin test, Mazzini test for syphilis, and stool examinations for parasites. If tuberculin tests are positive they are followed up by chest X-rays. If sedimentation rates are high and there are other possible indications of rheumatic fever, electrocardiograms are made. If a child's test for syphilis is positive, he is referred to the Kanawha Medical Center for treatment.

Special laboratory tests—such as basal-metabolism tests and blood chemistry and special X-rays—are obtainable at the Charleston General Hospital and may be paid for from State maternal and child-health funds.

When patients require hospitalization and, therefore, daily observation and supervision, one of the two pediatric consultants connected with the State department of health assumes responsibility for this hospital care.

As might be expected, our chief difficulties have been with minor details. Our fee schedule is in accordance with all those in public-health programs throughout the State. That fact makes it acceptable to all hospitals and institutions, and therefore fees present no problem. At first there was a great deal of confusion in coordinating our services with those of other clinics, and of the out-patient departments of hospitals, and of private specialists. But through conferences this has at last been ironed out to everyone's satisfaction.

We have not yet solved the problem of a satisfactory record form to use in the clinic. We started with a form that was adapted from one in use in the Kansas schools. This proved to be too small, and we abandoned it in favor of one already in use in the rheumatic-fever program of our State health department. However, we find that this is too cumbersome, and we are now planning to return to a modification of the first form used.

Another of our difficulties is the inadequacy of our dental services. To date, we have no dental services available except those offered by a clinic set up in one of the Charleston schools. This clinic is open only to residents of the city—not the county. Plans are under way, however, for obtaining the services of a dental hygienist from the State health department and expanding the clinic facilities so that patients outside the city limits may be cared for.

The clinic has now been in operation for a year, and during that time we have seen 110 patients, with a wide range of diagnoses.

Our diagnosis brings hope

One of the more interesting cases was that of a 14-year-old girl who had been excluded from school because her vision was too poor for her to do school work. This child had a draining sinus just below the inner corner of her right eye. She had been hospitalized twice; glasses had been recommended and an eye operation proposed. However, our clinic discovered that she had congenital syphilis, and this diagnosis showed that neither of these measures would be helpful. But it was hoped that prompt institution of antisyphilitic therapy would restore at least part of her vision and clear up the lesion below the eye.

Another case was that of a 12-year-old girl whose history revealed she had been taking a tremendous dose of phenobarbital daily. She was buying the drug from a mail-order drug company in Chicago. These large doses made the child behave strangely at school; for this reason she had been referred to us. With the proper therapy, including psychological guidance under the supervision of the mental-hygiene clinic, this girl has shown remarkable improvement. The matter of the mail-order sales to her was promptly reported to the Food and Drug Administration of the Federal Security Agency for investigation.

The majority of our cases continue to be recurrent upper-respiratory infections, malnutrition (including feeding problems and poor eating habits), and behavior problems, in that order. It is interesting to note that approximately 50 percent of the children seen in the clinic have secondary anemia, of varying degrees of severity.

Since the beginning of the program seven patients have been hospitalized for reasons other than tonsillectomy. Three of these were for surgery.

Nutritionist advises the mothers

A nutritionist took the dietary histories of 55 of the children who have attended the clinic. A few mothers were not able to give all the information about their children's food intake that the nutritionist asked for, but for the most part what the mothers gave seemed to the clinic staff to be fairly accurate.

These histories brought out a number of facts about the eating habits of the children. Of the 55 children whose diets were recorded, 33 were found to have a poor diet and 19 a fair one, and only 3 were considered to have a good diet. Of the 3 who had good diets, 1 was a child with diabetes who was under the care of a doctor: a dietitian was helping the mother plan the child's meals.

In noting the use of certain foods, the nutritionist found that the diets of 43 children were very deficient in green and yellow vegetables; only 4 seemed good in that respect, and the remainder fair. Milk and meat ranked about the same in the diets, with 5 good, 28 poor, and the remainder fair. The intake of citrus fruit or tomatoes was found to score 44 poor and 5 good, and the remainder fair.

Half the parents reported that their children were eating too much between meals, thus spoiling their appetite for meals.

The condition of several of the patients was diagnosed by the examining physician as definitely caused by malnutrition.

In one outstanding case, a remarkable improvement in eating habits was shown and, consequently, an improvement in the physical condition of the child. When this little girl came to the clinic, she was pale and thin, her posture was poor, her arms and legs were emaciated. She had a thin, pinched face with a very unhappy expression. She showed definite signs of anemia. Her mother reported that the child had a very poor appetite. She had a habit of eating sweets between meals and very little food at mealtime.

When this child started to eat more of the essential foods, she began to gain in weight, to look much better, and to feel better; she had a much more pleasant expression on her face and seemed like an altogether different child. She gained 8 pounds in 6 months.

Another interesting case is that of an 11-year-old boy who was overweight. He ate large quantities of high-calorie foods and neglected to eat some of the highly nutritive foods that are low in calories. The pediatrician in charge of the clinic ordered a low-calorie diet for the boy. The nutritionist talked with the boy and his mother together and tried to show the boy that changing his food habits would make for better health and a happier boy, and, at the same time, would reduce his weight. He showed much interest in what was said to him and said that he and his mother would cooperate on the project.

This boy's second visit to the clinic took place a month after the first. The boy and his mother reported that he had been following his diet very closely. He was learning to curb his appetite for high-calorie foods, and he had lost 4 pounds.

Again, we had a boy whose mother had to work outside the home to earn the family living. His mother did not take much time to plan meals for the children, but allowed them to eat about what they wished. Naturally, they neglected some of the important foods. The nutritionist tried to explain to the mother the importance of planning adequate meals that include a variety of foods. She stressed the importance of helping the children to learn to eat a number of different foods. At a later visit to the clinic, the mother said that she is now giving more time and thought to the food needs of the children. Green vegetables, eggs, more milk, and some other foods that had been greatly neglected are now included in the meals. The boy who was referred to the clinic is now learning to eat a greater variety of foods.

Medical social worker adds her skill

Our medical social worker has seen about half of the children attending the clinic.

Many of the children come from large families whose inadequate and uncertain income and crowded living quarters add tension to family relationships and place a heavy burden on the more insecure or emotionally immature parent. Settings such as this provide poor background for good physical and emotional health, and in her interviews the medical social worker learned that a large proportion of the children had a history of nervous tension and poor school achievement. Often other members of the family, too, showed need for help with physical and emotional problems that could be met either through our clinic or some other of the various community agencies.

As the child's whole health problem is so closely related to the setting from which he comes, and as his care in turn will affect his family, the medical social worker helps both the child and his parents. Therefore she needs to know what all the members of the family are like, what feelings they have toward one another, and what attitude the parents and the child himself have toward his medical care. If the parents are in conflict, and their own feelings are mixed up, case-work service may be of help to them in fulfilling more adequately the physical and emotional needs of the child. As a byproduct, the service may result in better adjustment and better health for the whole family.

Girl helped to lead more normal life

One patient, Eleanor, was sent to us at the age of 15 because she had epileptic seizures. Her behavior at school was bizarre. Her middle-aged parents had reared a large family and were now rather at a loss to know how to help this child in solving her individual problems. The electroencephalogram showed that she had true epilepsy. Her intelligence was rated as low normal.

Under a doctor's care, Eleanor's medication was regulated so that her seizures were controlled. She also became alert. Her condition was explained to the school officials so that they would be understanding of the problem. Previously she had been scolded, because the teachers thought Eleanor had the fits on purpose.

Now she works an hour a day in the school office. Her school work has improved and her grades are good. Much help has been given the parents by the medical social worker in understanding Eleanor's need for more freedom and in preparing her for the time when she must stand alone. Eleanor's father thinks watching school games is sinful, but he is willing to have her bring friends home. She now spends week ends with her older brothers and sisters, where she has more social outlets, such as an occasional movie, picnic, or party.

From a rather sullen, lethargic girl, Eleanor is developing into a pretty, sociable young woman. Her parents are very proud of the change in her.

Johnny and his parents are helped

The medical social worker found that Johnny was a malnourished child of 9, with a history of continual colds. His paternal grandmother and aunts monopolized him, putting his mother into a sort of second place with him. His father after serving in the Army found jobs hard to hold because he wanted to start at the top. Although the boy's mother had a good education, she seemed to be without the slightest initiative and looked drab and unattractive. A tonsillectomy improved Johnny's health, and the nutritionist gave his mother help with meal planning and food budgeting. The mother came frequently for interviews with the medical social worker between Johnny's clinic appointments.

The mother's personal appearance has now improved; she wears makeup and freshly pressed clothing. She has taken a merit-system examination and looks forward to obtaining work so as to increase the family income. She is much more positive in her relation with Johnny and is feeling less subdued in the presence of her husband's family. Johnny, as the result of all this, is a much healthier and happier boy.

How the public-health nurses help

The public-health nurse finds the children who need our services, helps them to receive successful treatment, and follows up to help the parents carry out the clinic's recommendations.

Whether the primary purpose of a nurse's visit to a home is to see a pregnant mother, or some other member of the family, she usually finds a child who needs the services provided by our clinic. When she finds such a child, she tries to prepare the parents and the child so that the clinic experience will be as pleasant as possible. At the clinic, she tries to see that the children are happy. For example, she provides opportunities for them to play together while waiting.

One of the two public-health nurses who work closely with the other clinic personnel helps the doctor with his examination. The other nurse explains to the parents, and sometimes to the child, the medical findings and recommendations; sometimes she needs to guide them to other community resources. She coordinates her work with that of the doctor, the medical social worker, and the nutritionist.

The nurse closely observes the child's progress at home and in school, and when he needs additional care she helps in getting him back to the clinic.

In the case of Johnny, mentioned previously, the nurse recognized that the state of his mother's health was jeopardizing the chances for improvement in his own health. And so she planned with the mother to meet her health needs, and helped to see that she received medical care. After the mother was treated for a secondary anemia, she showed greater interest in Johnny's health and followed clinic recommendations.

The nurse is ever alert to children's health needs—physical and emotional—and she works to help them to be healthy and happy.

A joint review by the clinic staff

One of the more valuable parts of our work is the postclinic conference, at which the clinician, the social worker, the nutritionist, the clinic nurse, and the director of the city-county health unit sit down together to review and discuss the various aspects of cases—the diagnosis, the medical treatment, and the socioeconomic factors in the child's life.

We exchange notes

At this time each worker asks any questions he wishes. The director of the health unit, for example, finds out what he should do for the child. The clinic nurse gains information that helps her in instructing the nurse who will make follow-up calls in planning the patients' future relation to this clinic or to other clinics. Also, administrative problems that come up are ironed out at these sessions.

Procedure to be improved

At present, a summary of each patient's contact with the clinic is sent to the referring source only after the patient has been discharged from the clinic. But in the near future, when we hope to have more clerical help, we plan to send a letter at the time of the child's first visit to the clinic, acknowledging the referral, giving the tentative diagnosis, and outlining the proposed plan for diagnosis and treatment.

The outstanding characteristics of our program are: (1) We try to see that every child referred to us receives complete health care; (2) we run the clinic as an integral part of the program of a local health department; and (3) we spend comparatively little money.

What about money?

As for the cost, we can report that during the clinic year recently completed we spent only about $2,000 (exclusive of regular health-department expenses such as salaries and rent). Of this sum, $465 was for the salaries of part-time clinicians and laboratory technicians, and the remainder was for laboratory work and hospitalization. Of course, we are fully aware that without the use of the health department's facilities we could not have done the work at this small cost. However, we feel that our experience may serve as a stimulus to other communities to try to see what can be done without much money, and we hope that in the near future similar clinics will be established elsewhere in our State.

ADOLESCENTS HAVE SPECIAL HEALTH PROBLEMS

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YOU may well ask why there is a need to give special consideration to adolescents' health and how their health problems differ from a child's or from an adult's. It may seem to you that this title suggests the need for another specialist, for someone especially trained in the care of the teen-age group. Adolescents *do* present problems peculiar to their age; a few of their problems will be discussed here, but they are not grave and they do not require another specialist.

Adolescents chiefly require that the family physician, the pediatrician, and parents and teachers treat them *as adolescents*—not as little children, not as adults. They are not little boys or little girls any more; they aren't adults yet; they are individuals who are *beginning to be adults*. When this fact is really understood many of the matters characteristic of adolescents will no longer be problems; if it isn't, the adolescent will continue to be an enigma.

The attitude adults take toward adolescents is much more important than a knowledge of those few medical conditions that are peculiar to, or of special significance in, that age group. A brief discussion of a few of those topics may, however, be of some value, and it will give further opportunities to reiterate the necessity of interpreting these individuals in terms of the particular age group to which they belong.

They want to know about maturity

No subject that concerns adolescents needs more special knowledge and attention than does growth and development. The 8- or 10-year-old child and the 30-year-old adult have little interest in height or strength or weight or state of maturity; interest in those matters is either ahead of or behind them. But to the adolescent boy they are matters of vital concern; he wants to know if and when he will be taller, when his whiskers will be as obvious as his friends', whether his chubbiness is going to persist. Those matters are serious to him; they often need patient explanation and understanding.

If an adolescent is tall and heavily bearded at 14, he will be expected to be as responsible as his appearance suggests he should be, and yet he will be told he is only 14 whenever he seeks the "privileges" usually granted to the 17-year-olds he resembles; little wonder that he seems rebellious when restricted, and is awkward when allowed to "act his size." The 16-year-old who shows no signs of needing to shave, and who may be no taller than many 14-year-old boys, may worry—may think he is "abnormal." His anxiety will be intensified by height-weight-age tables and by thoughtless adults who believe that an "average" height is the optimal one.

There is nothing orderly about growth during adolescence. There is no one way of growing or maturing that is better than another. One boy or girl may at 14 have arrived at practically an adult size or state of physical development; another at 16 may be little different from many at 13. Neither is abnormal, and yet obviously neither is "average." Real abnormalities in growth are rare; wide variations from the average are common.

What is needed is to understand this so that some adolescents who vary considerably in one direction can be reassured that they *will* grow, that they *will* mature; and so that others who deviate as much from the average in the other direction can be understood for what they are—just overgrown colts—not what they seem to be. All of them need to learn that there is no way of growing that is better than another, that their way is the best way *for them*. A few will need more reassurance than that; a rare one who has made no progress toward growing or growing up or who has matured or grown very rapidly should have a careful examination.

Each grows in his own way

Too much examining, too early and too impatient a use of "hormones," too much or too thoughtless a comparison with "average" tables, an off-hand comment that "you need thyroid," can convince a perfectly normal adolescent that he is abnormal. To be abnormal in growth or development is a very serious matter in the mind of a 16-year-old.

There is no better way of demonstrating the wide variation which exists among 14-year-olds than to measure and examine a large group of them. All shapes and sizes and states of maturity will be there. Very few will be just "average," but there will probably be none who is really abnormal. If adolescents can be made to understand that each grows in his own way, that one way is no better than the other, they will be spared at least one source of anxiety.

There is a tendency to protect young children from measles and mumps and chickenpox and whooping cough; this may be desirable if a child has recently had a severe illness, but otherwise it is short-sighted prevention. To avoid chickenpox in childhood is to invite it in adolescence, when absence from school is of more consequence; to defer mumps from childhood to adolescence is to transform it from a minor ailment to a disease whose complications (orchitis, for instance) can be of significance.

There is no question that immunization against such illnesses as smallpox, diphtheria, and tetanus is imperative; such diseases are too serious to risk at any age, but efforts to prevent children from having some of the mild illnesses are rarely wise. It is never "convenient" to have chickenpox, it always spoils a school attendance record to have mumps, but it is better preventive medicine to get them over with than to defer them until adolescence or adulthood.

Aside from the business of "getting them over with," there is something to be said, from the standpoint of mental health, for not making a fuss about preventing them. Some illness is inevitable and it is wise to let children learn to accept, not fear or dread, *all* illness. After all, even a cold and "flu" have some immunizing value, and an occasional illness can keep us from losing all sympathy with the sick. The way to avoid letting the contagious diseases be a problem in adolescence is to get these minor ailments over in childhood!

Adolescents need immunizations

Only one other matter relating to infectious diseases is of particular relevance in adolescence. Immunizations against smallpox, diphtheria, and tetanus should be taken care of during a child's first year and repeated every few years; too often these are forgotten during adolescence. Those initial immunizations won't protect forever; the chances are that after a few years every one of them has lost its effect. If any one of them has not been given within the previous 5 years, it should be given attention in adolescence.

Strenuous activity will not hurt teen-age boys who are well, and well-conditioned by exercise.

A "booster" dose will probably suffice for tetanus toxoid; a Schick test will tell if there is still immunity against diphtheria; a revaccination will take care of smallpox. Adolescents need this protection. Because they had those immunizations in childhood and because adolescents usually seem so healthy, it is easy to forget to renew them. None of those diseases is limited to childhood; they are just as prevalent, if not more so, in adolescence and adulthood.

How they look at health and illness

The most important part of an adolescent's health education, his attitude toward health, starts in early childhood, but it needs reinforcement from time to time; and also a few new facts and matters are appropriately added as he gets older. If, because of faulty training and exposure to bad example, he has failed to develop a rational and objective way of thinking about illness, if he tends to use symptoms as an excuse, if he has the "pill habit," it isn't too late for us to try to change all this. Certainly, no bit of factual information is as important as his attitude toward health and illness. It is of more consequence for him to view illness objectively, for him to be more interested in finding causes than in taking pills, for him to avoid hypochondriasis as well as recklessness than it is for him to acquire a smattering of physiology.

Given a healthy attitude toward health, the adolescent will benefit from some factual information. He should know something about growth and the different but normal ways in which young people mature. At this age he is capable of learning more about nutrition.

Mature judgment and reluctance to "take a chance" are hardly typical of adolescents; ways to avoid accidents is one of the most important of their health-education subjects. Many of them will want to know something about acne, how much sleep they should have, and whether strenuous exercise is really harmful. Sex education has real meaning for them now, and simple matters of mental hygiene will be better understood. Their interests and needs in this field are genuine—and not identical with those of children or adults.

Teen-agers and the doctor

An adolescent's answer to such questions as how he feels or whether his vision is bothering him is usually a denial that anything is wrong. He doesn't want to think that anything is the matter; he resents the implication that he has what he considers to be an abnormality.

So his denials need interpretation, and his sensitivity to thoughtless comments is worthy of attention. He doesn't find it "interesting" that he has a supernumerary nipple; he will have to be assured that it isn't a cause for worry or shame. A "variation from the norm"—an "abnormality"—is never insignificant to him. He isn't a little boy any more, he isn't a man yet. The adolescent wants to be like everybody else; he doesn't want to be unusual. His little brother doesn't care; he doesn't even mind "My, how you've grown" very much; and his father will boast about having the most unusual hernia the surgeon ever repaired.

Not only these attitudes toward various findings, but the interpretation of the findings themselves, and some of the things one looks for, are different in adolescence. High blood pressure, particularly in youngsters who are tense, or are unused to medical examinations, is common, but only very rarely of any significance. Albuminuria is not usually a sign of kidney disease, when found. Only very rarely should either of these findings be considered to be of any consequence. Basal-metabolic rates are liable to misinterpretation: In adolescence they fluctuate considerably from time to time, their normal limits are wide, and the basis for their calculation is at the best only approximate. The adolescent's thyroid is far from stable, but in time it will straighten out if it is left alone. If an adolescent's thyroid really seems worthy of attention a serum cholesterol determination is a better supplement to an evaluation based on his general appearance, on the moistness of his palms, and on his heart rate than is his basal metabolism. There is a real difference between mother's "putting on a little weight" at 40 and Susie's or Billy's chubbiness at 14; they probably don't need any "thyroid" even though it may be desirable for her.

Backache—lower back strain—is relatively common in adolescence. In this age group special causes are to be looked for, and different types of treatment may be successful. At all events the back is not just to be strapped with adhesive, and the backache is not to be regarded as something that is unfortunate but to be interminably endured. Either inflammation or deformity may be present in the spine; an X-ray will determine that. Bad posture, a protuberant abdomen, and a deep lower back curve may be the aggravating factors. Flabby, weak muscles may need strengthening. There are things to do for an adolescent's backache: rarely surgery—and frequently exercise (after the acute stage) rather than rest—will be beneficial.

At an adolescent's medical examination there are a few things to look for which are of more significance to them than to older or younger people. Acne is the bane of their existence. It is difficult to treat, but to say you can't do anything for it just adds discouragement to dismay. It is just as important to make a few suggestions as it is to explain the relation of acne to the process of maturing. The status of his or her color vision may be of consequence to the boy who wants to be an aviator or the girl who is planning on a career in interior decorating. Pilonidal-sinus infections and plantar warts are at least a nuisance and should be cared for. A testis still undescended after puberty probably requires an operation; to wait longer is to invite its sterility. Not the least of the values of the adolescent's health examination is the opportunity it affords for getting acquainted with the one whom the adolescent should regard as his own physician—not the family's, but his. It offers a chance to ask questions, to get advice, to talk over matters which concern him. Be sure that by the time they are adolescents, boys and girls go alone to the doctor: it is *their* examination, *their* health. It should be their chance to seek advice and ask questions.

When they feel disturbed

Major psychiatric difficulties are not common in adolescence, but the number of adolescents who are partially or temporarily handicapped by minor disturbances of their mental health is large. The precipitating factor will often differ from those that affect an adult (it may be the loss of a "best girl," or failure in school, or worry over failure to mature, or inability to reconcile the acceptance of authority and the desire for independence), but the disorder can be as acute and as demanding of attention as an adult's.

Don't attempt too much

The treatment, however, can differ from that given an adult. It can be more brief; it usually need not be as thorough. Adolescents usually talk more freely, get what is on their minds off more quickly, and seem to benefit more from less intensive treatment than do adults. That is not to say that all they need is a chance to talk things over; often they require much more than that. But they apparently benefit most when not treated in too ponderous a fashion, when too much is not attempted, when the physician or psychiatrist has a good understanding of the problems and attitudes and groping for understanding peculiar to them.

When they really need a psychiatrist's help they readily accept it; they have no prejudice or embarrassment unless it has been aroused by an adult who felt that there would be reluctance, that there was need for coaxing and persuasion. It is good for them to learn young that their mental as well as their physical ailments are amenable to treatment.

What failing in school can do

Neither parents nor physicians need to try to become experts in educational matters, but failure in school is of so much importance to an adolescent's mental health that it often has to be considered as a possible cause of some of his physical as well as psychological difficulties. Most adolescents want to do well in school; they may not like school, but most of them appreciate the value of an education. Those who say they don't care are usually rationalizing, protecting their self-esteem. However, not all people were ever intended to be students; some do not have the capacity, others have no interest in academic subjects; a few have specific disabilities that are a handicap in school.

Nausea, headaches, fatigue, behavior problems—all those and many more may arise out of the frustration and anxiety which failure in school produces. An adjustment in the school program, a decision to pursue a course based on the child's intellectual capacity rather than a parent's hopes, a correction of poor vision or hearing, or the detection and remedying of a language disability may well eliminate the symptom or solve the personality and behavior difficulty.

Confidence may be lost

These matters are more acute in adolescence than at other ages. Failure in school at this age means that a decision to continue or to drop school must be made; when it occurs in those who have done well during the easier early grades, it can be depressing and lead to loss of confidence and to feelings of inferiority; it means that a hoped-for career may have to be abandoned. School failure affects younger children and persons in their twenties, but at no age is it so apt to cause trouble as in the early teens, when it cannot easily be excused on the basis of childishness or dismissed with the comment that "he might as well go to work."

Tonics, vitamins, eyeglasses, thyroid, or more discipline won't help a youngster who is "run down," who fatigues easily, or who has eyestrain or emotional outbursts, if his real trouble is his worry and a feeling of frustration over failure in school. It is a cause of these symptoms which has to be given consideration at this age more often than do anemia, infection, or metabolic disturbances.

Let them exercise

Little children play games; adults are interested in athletics; but teen-age boys are violent competitors. They go at their games hard; they take them seriously. Athletics are important to them; they offer an outlet for their excessive energy, an opportunity to learn to win and lose gracefully, for developing the spirit of cooperation and team play. Not to appreciate their significance, to underestimate their importance in the boy's mind, is to make a considerable error; the decision to tell a boy that he has to give up some game should not be made lightly.

There are very few adolescents who should not be allowed to compete in athletics. There is no danger of their being "strained" if they are properly trained, and very little danger of their being injured if a few precautions are taken. Even the boy with heart disease can be found a place as a "goalie." It is important to try to make him feel that he is little different from others, that he can be part of a group.

We should realize that adolescents are not children, not adults—they are in a transition stage.

A boy who is "well-conditioned" won't be "strained." The way to get him into condition, so that strenuous exercise won't tire him too much, is to let him exercise. The more he is protected from being strained, the more he is rested, the more likely that subsequently strenuous exercise will strain and overtire him.

If we are sure that he is well, has a good heart and lungs, and doesn't become so tired at his exercise that he loses weight, has little appetite and sleeps poorly, there is nothing to worry about. Too much restriction, too much solicitude, make for more maladjustment and neuroticism than protection from such a remote possibility as damage from exercise can ever justify. The admonition "avoid fatigue" doesn't promote the development of a state of physical condition which would itself be the best safeguard against strain and fatigue.

Adolescents, their ailments, their physiology, their behavior, their attitudes, their activities—all the matters that affect their lives and their health—need special consideration. They aren't "problems." Adolescence is much too hopeful an age; "problems" has much too gloomy a sound. The adolescent's outstanding characteristic is his capacity for change; his growth, his behavior, his physiology have not yet settled into their adult molds. That may make him a little more difficult to understand (it certainly makes it imperative that we not judge him by adult standards!) but it permits us to believe that time—and a little humble guidance—may be all that is needed.

TEAMWORK FOR BETTER HEALTH PROGRAMS IN SCHOOLS

H. F. KILANDER, *Assistant Specialist for Health, Office of Education, Federal Security Agency*

IF a program for the health of school children is to succeed, everybody concerned in it—teachers, school administrators, and others—should understand the goals of the program. Every teacher, especially, should be well prepared for his or her pivotal part in carrying out this important phase of school work. Many of the teachers graduating from teachers' colleges within recent years have received such preparation; but large numbers need to be prepared on the job if they are to help carry out the health program in today's schools.

Work conferences are increasing

Improvement of health programs for the school-age child owes much to the development, over the last two decades, of work conferences. An informal count showed that about 300 such meetings on various phases of the health of school children were held in 1948. And undoubtedly as many, or more, have been held in 1949 and will have been held in 1950 before the year is over.

These work conferences on health services for school children are a form of in-service education that has grown out of the old-time teachers' institutes. The chief difference between the old way of helping teachers to teach better and the current on-the-job way is that the present method follows the principle of education that learners should take an active part in their own education. The work conferences are democratically organized. No longer do teachers listen to lecturers for the full duration of an institute. No longer do they get their in-service training with other teachers only. Now, in the successor to the institute, all members have a definite responsibility in the probing into actual problems. These are problems that members of the group have encountered in their work. The conference attempts to work out ideas that members may put into action at home and so solve the problems discussed.

Teachers may find that their fellow conference members, besides other teachers and school administrators, are nurses, doctors, dentists, nutritionists, social workers, members of school boards, or representatives of parent-teacher associations. The nurses and doctors are usually from the public-health field, either from official health agencies—State or local—or from voluntary health agencies. The differences in thinking that exist among workers of different professional backgrounds are valuable in a work conference like this. They tend to insure that all angles of a problem will be explored and they bring out each member's best explanatory efforts to make his position clear.

How do these conferences work? Here's a brief answer to that question. (In the next article, "Arkansas Works to Improve Its School Children's Health," Jeff Farris describes a series of such conferences.)

How a conference gets under way

A staff is necessary, of course, headed by a director who is qualified in the techniques of democratic group study, sometimes called "group dynamics." The director and those responsible for the work conference arrange for the services of specialists to serve as consultants—in this instance, specialists in the field of health services for children of school age. These consultants compare with the authorities who used to lecture at teachers' institutes. In the work conferences they work *with* the group so as to bring out best the fund of knowledge and experience that members have, as well as to place their own specialized knowledge and experience at the service of the group. They help members keep their different interests, attitudes, and opinions focused on the problem under discussion, and they guide the talk persistently toward a solution of the problem under discussion.

Because many of the members of a work conference may be unfamiliar with the way a group like this gets its work done, the first session is usually taken up with a thorough discussion of the methods usually followed. After this setting of the stage, the problems to be discussed are listed and a way of classifying them into groups for study is considered. Perhaps a committee is elected to do this classification.

At the second session, this committee reports. Discussion of the report and acceptance of it makes the formation of "working groups" possible. Each group will concentrate on one problem—possibly more than one, depending on the number of problems and the number of members of the work conference. The best size for a work group has been found to be from 10 to 15 persons. That number usually assures enough information and experience within the group to make discussion profitable, and yet it is small enough so that everyone can be expected to contribute to the discussion. Members continue in the same work group during the whole conference. They are free to choose their group.

How are expenses met?

The director and the consultants decide which groups the consultants can work with to greatest advantage. They help their groups get started, but after a chairman and recorders have been elected, the consultants confine themselves to their advisory roles, doing no directing. Other groups may call upon them for specific help. They stay with those groups only as long as it takes to give the advice asked.

Each group examines and defines its problem and plans the way to study it in order to arrive at a conclusion. The work groups are coordinated so as to avoid wasted effort and duplication in the subject matter discussed. This is done through periodic progress reports from the work groups to the whole body and by meetings of the director, consultants, chairmen, and recorders.

If evaluation of the work conference

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ARKANSAS WORKS TO IMPROVE ITS SCHOOL CHILDREN'S HEALTH

JEFF FARRIS, Executive Secretary, Arkansas Health Education Workshop Committee

ARKANSAS has just completed its third work conference on health education in its schools. This makes three such conferences, held in three consecutive summers.

The 1950 work conference has come up with tangible accomplishments. One is the writing of a handbook on school health programs in Arkansas for the use of school superintendents and principals. Another is a report of the progress made by certain "pilot" school centers in the special phases of the school health program on which they have been concentrating.

Definite plans for further extension of health programs grew out of the 1950 conference. The colleges of the State participated. Study groups will be formed during the 1950–51 school year in each district of the State where teacher-training institutions are located. All public-school and public-health people in these areas will be invited to participate. These invitations will be given by the State departments of education and health.

A section of the annual meeting of the 75 county school supervisors has been allocated to the health of the school child.

Looking ahead

Plans are already in the making for another series of conferences during the summer of 1951, designed to study the effectiveness of the "Handbook for Health in Schools," prepared at the 1950 conference.

A joint committee of key people from State departments of health and education, formed at the 1949 conference, is functioning and will devote most of its efforts during the coming year to promoting the use of the handbook.

But first I want to say that this summer's work is not the first accomplishment of the series of work conferences—also called "workshops"—nor is it the beginning of the series' influence on the development of an effective school health program in the State. The work conferences are providing a good share of the motive power for the State's current efforts to improve its health services for children of school age.

To point the way

These efforts take the form in Arkansas of a "pilot school health program." That means that a few school centers in the State have been selected to develop a complete health-education program. These can serve as examples of what can be accomplished if all a community's services for children are focused on the schools in the interest of the children's health.

The idea for this pilot school health program was born 3 years ago on a hot June night in the men's washroom of a parlor car as it sped toward Little Rock from Florida. A small group of Arkansas educators were returning from the 1947 meeting of the Southern States Work Conference at Daytona Beach, where 2 weeks had been spent in studying the school health problems and wider community health problems of the Southern States. The consensus of the Arkansas group was that in their State, where far too little was being done for the health of the child of school age, the idea of accomplishing more should be pushed beyond the talking stage. In the group were a representative of the State department of education and of the State board of health and a faculty member from Arkansas State Teachers College.

Representatives of these three agencies, meeting some weeks later, decided to start the ball rolling. They planned to select a few school centers in which they knew they could get cooperation from the school administrators for building up, through close cooperation from the three State agencies, a complete health-education program. These school centers would serve as pilot centers to demonstrate what a well-planned, thoroughgoing, well-supervised program could do to improve health conditions, health attitudes, and health instruction in the schools and in this way to help children to be well and to be interested in keeping well. Such a program would be manned, or backed, by doctors and nurses of the community (including those on the staffs of official agencies and private practitioners as well) and teachers and other school workers.

We choose three pilot school centers

Three school centers were chosen—one in a semirural community, one in an industrial area, and the third in a city where the school system has reasonably good school health services and a qualified staff.

In each center a complete health program was put into action. To that basic program of three parts (health services, healthful school living, and health instruction) two other parts were added in each of the centers chosen. One of these was a public-relations program planned to keep the people of the areas informed of what was going on and to bring them into the work in every way possible. The other part added was the evaluation of each school-health program as it progressed in a pilot school center.

The idea of having a complete school health program was well received by the people of each center chosen, as well as by the school administrators, and so the work got off to a good start.

At the end of the school year 1947–48, key personnel from each of the five pilot school centers met to review what had

At the Arkansas work conferences on health programs for school-age children, key personnel from the pilot schools meet to review and evaluate what has been done under the programs.

been done under the new program. The meeting was a 2-week work conference, arranged jointly by the State board of health and the Arkansas State Teachers College. The setting of the conference was a delightful mountain lodge—Mather Lodge—in wooded Petit Jean State Park. The participants—40 in number—were key staff members from each of the pilot centers, aided by 4 consultants. One of the consultants was from the Office of Education of the Federal Security Agency, one from the Virginia State Department of Education, one from the North Carolina State Department of Health, and one a member of the staff of the American Medical Association. The Children's Bureau of the Federal Security Agency, through the Arkansas State Board of Health, provided funds for the conference.

The 1949 and 1950 work conferences were also open only to selected school administrators and teachers from pilot school centers and from other school systems especially chosen, and to public-health nurses, sanitarians, and health educators individually selected by the State board of health. Sixty attended in 1949, an increase of 20; but 60 is the limit of attendance because no more than that can be housed and fed at Mather Lodge.

The 1948 work conference established a permanent organization—the Arkansas Health Education Workshop—with an executive committee empowered to continue operation in the years to come. This permanent organization decided (1) to keep on with the work in the original pilot centers, (2) to start work in at least five new centers during the following school year, and (3) to hold another workshop in the summer of 1949. The report of the 1948 work conference disclaims completeness or finality, but it is comprehensive enough to be of practical help to school staffs and groups interested in planning school health programs.

As we workers had hoped, the idea of more and better school health programs caught on. Many schools asked to be selected as pilot centers for the 1948–49 school term. But our supervisory workers were so few that the number of schools had to be limited.

However, the executive committee of the Arkansas Health Education Workshop decided to establish five more centers, two of which would comprise all the schools in two counties. Both counties are mountainous, and the people are largely rural.

It was in these two counties that some of the most interesting accomplishments came about. Arkansas State Teachers College agreed to parallel the programs in these counties with a field course in health education, giving credit of six college hours to teachers completing the course. One hundred and thirty-nine teachers enrolled. Results were beyond expectation. Fathers and mothers came from all parts of the school districts to hear the program explained. School busses brought the parents to the meetings and took them home. The children entered enthusiastically into all phases of the program. The doctors, nurses, and dentists of the localities gave willingly of their time and skills, often with little or no remuneration. Health councils were established in all the school centers and became the agencies that activated the programs.

Parents formed study groups for learning more about what school health programs could do. These groups scored in practical accomplishments as well as gains in knowledge. They helped to repair some of the school buildings, long in need of attention. Most of the local civic clubs asked simply, "What do you want from us?"

One of the outstanding results for the teachers who took the field course in health education was their new knowledge about the emotional development of children. Some of them learned for the first time of how vitally important a good, understanding relation between teacher and pupil was to the emotional health of both. Few, if any, of the teachers complained because the health-education program added extra work to their daily schedules, already full. The school administrators not only were cooperative but were eager to have their units meet all standards set as a minimum for the program and then surpass these standards.

A second 2 weeks' work conference was held the next summer—1949—in the same mountain lodge. Again, 60 persons, most of them from or connected with the pilot school centers, were selected to take part. Funds from the Children's Bureau again made the work conference possible.

The subject matter discussed was realistic, as it had been before. It was made up of problems that had become evident during the winter in the pilot school centers and had been listed for the attention of the work conference. From the list of 34 problems, a committee selected for study 6 that it considered of major importance. The committee felt that the solutions arrived at would help newly chosen pilot schools in overcoming these very problems.

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WHAT ABOUT THE SCHOOL-AGE CHILD WHO IS EMPLOYED?

ELIZABETH S. JOHNSON, Chief, Division of Child Labor and Youth Employment, Bureau of Labor Standards, U. S. Department of Labor

MANY of us think of the daily activities of children of school age as getting off to school in the morning, doing classroom work for 6 hours or so, reporting home after school, and then enjoying the release of play suited to their age.

We know, of course, that they may do some other things after school, such as helping at home or practicing on the piano; and the teacher may have given them homework to do. But few of us realize that a great number of teen-age school boys and girls are employed regularly outside of school hours. In April 1950 there were 1,900,000 boys and girls 14 through 17 years of age at work. Of these, 60 percent had jobs and also went to school, and 40 percent had full-time jobs.

Some boys and girls may go to work even before they go to school in the morning, as well as working after school, and others begin their work directly after their school day is over. And, unfortunately, many work late at night as pinboys in bowling alleys, ushers in theaters, soda clerks in drug stores, and so forth. Many at 16 and 17, and some younger, have left school entirely.

Programs for the health of children of school age should surely take into account children in this age group who are employed, whether they go to school and are employed outside school hours, or have left school to take a job or to look for a job—and are still looking for it. Many of these boys and girls need health services as much as other children of that age—probably more.

For the protection of the children, teachers interested in their pupils' health will want to know what they do outside school hours. A child, especially an adolescent, may be doing something that is having an ill effect on his growth and development. He may have a job that in itself is too much of a strain for him—too long or too late hours—or is too dangerous for so young a worker. Aside from that, if he goes to school and works regularly at a job—whatever kind of job he has—this double burden may be entirely too much for him. In that case the teacher or someone else from his school should talk this situation over with him and his parents. The answer may be to shorten the hours of work or to defer employment until the child is older—or until a school vacation period. If the need for money is serious, student aid should be sought.

Is the job suited to his strength?

Program planners should surely see that health services are provided for boys and girls about to go from school to employment. Each pupil thinking of making this change should have a medical examination to determine whether he is in good physical shape for any kind of work permissible under the child-labor laws, or if he is not and therefore should do only restricted kinds of work. That is, he should have medical advice that will protect him from undertaking a burden unsuited to *his* particular strength and capacity. Much of the physical energy of boys and girls in their teens goes into growing; undue stresses and strains may cause a break in health, perhaps one easy to overcome, but maybe a really serious one.

Many States through their child-labor laws already require a medical examination before an employment certificate (also called a work permit or working papers) can be issued for a child to work. Most of these States require such an examination for children under 16 years of age, but the States with the best laws for the protection of young workers require it for boys and girls up to 18.

On the basis of a medical examination the issuing officer may refuse a certificate altogether, or he may issue a certificate limiting the child's employment in some way. This limited certificate permits the boy or girl for whom it is issued to work on a certain job for only a limited period, the interval to be stated in the certificate. This procedure allows time for correction of defects and provides an incentive to the child to get his

Children who are employed need as much health protection as children in school, if not more.

remediable physical defects corrected.

The problem of medical examinations for working children has received a great deal of attention from the International Labor Organization. International standards, in the form of conventions on medical examinations for young workers, were adopted in 1946. Two countries have ratified these conventions and they have served as a guide for many other countries wishing to improve their programs for working boys and girls.

Whether an employment-certificate system is to succeed in protecting the health of employed children depends largely on the strength of the laws requiring such certificates. All of us who are interested in strengthening health services for children of school age should give our support to State legislation requiring a medical examination before any boy or girl under 18 may enter employment. We should also work to improve the quality of the examination and to increase its use. It is desirable that the authorities responsible for issuing employment certificates designate the examining doctor and that he be one who is accustomed to considering the physical condition of boys and girls in relation to specific jobs that are offered them. Either the local health department or the health service in the schools may provide the physicians and other personnel and facilities necessary for the work. In any case, the examining physician will find that the child's health record is a useful aid in considering the medical history.

A medical examination for a child when he first enters employment is not enough. He should be reexamined each time he changes jobs. This is provided for in the better State child-labor laws.

These medical examinations for employment should be supplemented by follow-up medical care. A way for boys and girls to have their health defects remedied should be arranged for, if necessary, through community services.

Starting his work career is an important step in the life of a young person. It is also an important station in his process of growth toward adulthood. It is a time when he may be helped to enter a new phase of his life with the advantage of good health.

HEALTH SERVICES NEEDED

(Continued from page 9)

actually has heart disease, and even in this small group some are capable of normal activity. The fruits of accurate diagnosis in this instance are readily apparent. There are many more illustrations, such as the fat child falsely termed an "endocrine case" when he simply eats too much; or the child with large tonsils, which are actually normal at his age, who is started on the road to tonsillectomy too hurriedly.

The need for specially trained personnel and diagnostic facilities is by no means limited to those concerned with physical disorders. Emotional maladies are a conspicuous problem among children of school age, and resources for their diagnosis are essential to proper treatment.

Accurate diagnosis should do more than point the way to treatment. When a child and his parents understand the nature of an affliction they are more apt to seek treatment than when the problem is simply brought to their attention. Motivation as a factor in seeking medical care has been generally overlooked with the result that follow-through has suffered. Thorough understanding of a child's health disorder also leads to more sympathetic understanding and help from those who are around him. While scientific facts about an ailment are a primary concern only to those who treat him, a lucid explanation of the nature and significance of his troubles is also due those who give him nonmedical guidance.

More treatment services needed

The question of treatment services for children of school age coincides in many ways with the problem as it affects all ages: There is a scarcity of physicians, dentists, nurses, and others who provide these services, and most of those available are concentrated around urban centers. Treatment is usually expensive and there are many who cannot afford it unless the costs are spread out by insurance. There are also many people who, because of fear or ignorance, do not avail themselves of treatment when they might do so.

These problems are not new; they explain to a large extent the disparity that has always been noted between the number of children known to need treatment and the number who obtain it. The problem is magnified at the present time, however, by scientific progress, which offers a wider range of treatment services. There is therefore a great need to solve these problems so that the health needs of children in the school age which coincide with the needs of persons of all ages may be satisfied.

Treatment should include rehabilitation

The most pressing needs for treatment in the school age will not be met, however, by simple multiplication of conventional services that meet the usual requirements of all ages. The measures most needed are those for the relief of progressive disability and handicaps of nonemergency nature. Such a program will demand creation of new treatment services rather than expansion of those already in existence. It will also require broadening of the concept of treatment to include rehabilitation.

Some advances have been made in this direction, but so far they are mainly exploratory in nature. Programs for conservation of hearing, for rehabilitation of crippled children, for special education of children suffering from cerebral palsy, and for conservation of vision have already shown that this sizable section of the child population, who are not sick in the accepted sense of the word but whose development is seriously frustrated, has needs that have never before been touched.

Specifically needed is extension of treatment services mentioned above so that more children can be benefited. Also needed is wider development of facilities and specially trained personnel for dental treatment, alleviation of malnutrition, treatment of emotional disorders, correction of speech impairments, and treatment of epilepsy and allergy. The list could go on, for the health problems of children of school age, ignored or considered untreatable in the past, are numerous. Actually, they can be overcome or mitigated, but careful planning and special consideration for this age period will be required.

GOOD FOOD HABITS

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whether the lunch is nutritionally adequate. It is true that on cold days there is considerable advantage to serving a hot meal, although the advantage is psychological rather than physiological.

The research staff has explored ways of encouraging children to eat all the foods served to them and to try new foods. In cooperation with the classroom teachers, the lunchroom has developed as a laboratory for learning. Children share in menu planning; they have studied the way plants and animals are nourished; they have inquired about the resources of their community, and as a result home gardens have increased in number; their interest in social behavior and table manners has increased, with consequent demands to know how to set the table, use silver, and converse with one's neighbor; lessons in art, writing, and arithmetic have naturally followed along the lines of practical food problems.

And the results can be seen. The children are more alert; physical and dental defects are being corrected; more and more parents are coming to the schools and helping with some phases of the program; dentists, civic clubs, county agents, and other groups are sharing in some of the activities.

Members of the research staff have also participated in parent-teacher-association meetings; they have conducted workshops for training school-lunch managers; they have prepared monthly leaflets on nutrition and the school lunch, and nutrition materials for the use of teachers. All these things have been done in order to see whether the school lunch can be an effective means for improving the health and well-being of children. Sufficient progress has been made to give a positive answer with regard to its success.

Achievement of such a program demands the attention not only of the school-lunch manager. It also demands the concerted efforts of the classroom teachers, the parent-teacher association, the public-health nurse, the welfare worker, and all who take part in the care of children. These should all have a sound knowledge of the principles of nutrition and should also practice these principles in their own daily living.

ARKANSAS

(*Continued from page 35*)

The six questions were: (1) What is the responsibility of school and health personnel in making the child's whole environment conducive to his physical and mental health, and how can we fulfill this responsibility? (2) How can professional and nonprofessional personnel be prepared to carry through a satisfactory health-education program? (3) How can a specific health-education program be provided and integrated with all school activities? (4) What is the health-education problem characteristic of the average Arkansas school, and what can be done about it? (5) How can we provide more and better health services in the schools and in the community at large? (6) How can we extend the facets of a health-education program implied in the first five questions into all schools—and all communities—of the State?

The 1949 work conference decided that each school that had served as a pilot center for a year should, during the school year 1949–50, start to develop some special phase of a health-education program, such as making a complete evaluation of the program, or providing care for children needing special education, or rearranging a school plant and orienting its staff toward achieving the good relations between teachers and pupils that tend to promote a sound development of personality. The work done on these projects would serve as the subject matter for study in the 1950 summer work conference, which as THE CHILD goes to press, has recently ended.

If any one part of the work done in the Arkansas pilot school program can be called the key to its success, it is the thorough planning that was done with all local groups interested in the health of school-age children in the communities of the school centers chosen for demonstration. Only slightly less important in achieving the results is the complete cooperation among the three State agencies sponsoring the program.

What the people of Arkansas can thank the pilot school centers and the three sponsoring State agencies for is that the idea of promoting health-education programs in the schools throughout the State is on a determined march. Each step benefits children.

TEAMWORK

(*Continued from page 33*)

is to be attempted—an excellent feature to include—this should be planned at the first so that a reviewing committee can be elected and can work out a way to study the conference while it is in session. Its report usually points out the conference's successes and failures and makes recommendations for improving methods of work.

Many practical questions will arise in the minds of those to whom work conferences are new. How are the costs paid and how are the expenses of the members met, such as transportation, food, and lodging? These items may be paid for individually by the participants, especially when those who take part are students regularly enrolled at the college or university sponsoring the work conference. In other instances, provision may be made to meet the expenses of members through scholarships, fellowships, and stipends from a variety of sources, most frequently voluntary health agencies and public-health departments.

The work conferences on the health of school-age children that are independent of colleges are usually organized by voluntary health agencies. Often several such agencies pool their resources to finance the conference and to supply staff members and consultants.

What about credits? Most of the work conferences are connected with institutions preparing teachers; and credit, undergraduate or graduate, may therefore be given. The conference may not last as long as a regular course would last, but the amount of college credit may be determined by the time members spend in actual group study.

How long do conferences last? The most frequent length seems to be about 10 days or 2 weeks, although the range is from a few days to 6 or 8 weeks. A work conference's chief values are to thresh out difficulties that have arisen in the course of its members' daily work and to create enthusiasm for the program. It should not outlast the number of live, on-the-job problems.

This threshing out of actual difficulties in a democratic way is a long step toward achieving teamwork for better health programs in schools.

MENTAL HEALTH

(Continued from page 11)

class periods of the year, the student is being taught that this is a dangerous, anxiety-fraught area, which it is best to evade.

If mental health is something to be taught, discussed, learned, and practiced in every aspect of the schools' work, there is no easy way to provide it. The teacher, next to the parent, has the heaviest responsibility in developing a sound generation. She, or he, should be carefully selected, be trained thoroughly in child nature and child development, be highly paid, and be accorded a respected position in the community.

Meanwhile, we can be hopeful for and can do our best to foster certain trends. Teachers in practice are coming in increasing numbers to summer courses and conferences, and asking for in-service training in order to understand the emotional development of children and the relation between children's needs and the curriculum. Psychiatrists can endorse these courses and contribute to the teaching of them. Physicians can, as individuals and members of professional groups, reiterate in talks and papers the vital importance of good schools and good teachers—even if our school expenditures have to climb to the level of our liquor or cosmetic or tobacco expenditures.

I should like to add a word about the nursery school. Anyone who has worked closely with a first-rate nursery school, or with children who attend one, knows what a difference it can make in a child's spirit and in a parent's attitude. The therapeutic value of such experience has not received the scientific attention and clarification it deserves. Nor have possible modifications of nursery-school procedures been experimented with, to see, for instance, how diluted the schedule of attendance can be and still be helpful to children with various difficulties. This would seem a field of considerable promise, both for research and service.

To summarize:

Schools are a fertile field for mental-health efforts. A variety of approaches have been developed, singly and in combination. They can be most effective when combined. The psychiatric team, psychiatrist, psychiatric social worker, and psychiatric nurse can treat the most disturbed children, safeguard the therapeutic work of the guidance counselors and remedial teachers, and teach appropriate aspects of emotional growth—and disturbances—to the entire school staff. Guidance counselors and counseling teachers will have to carry most of the burden of guiding children with minor problems, at least until we have many times our present number of psychiatrically trained workers.

The guidance staff should have the advantage of psychiatric supervision, or at least consultation, whenever and as soon as possible.

School nurses and social workers can contribute greatly, especially if they have continued training or supervision.

Mental health in the curriculum should be an integral part of it, or rather the essence of it. This requires a long-fange program of teacher selection, reoriented undergraduate training, and, in the meantime, intensified in-service training in understanding and fulfilling child needs.

• FOR YOUR BOOKSHELF

HELPING BOYS IN TROUBLE; the layman in boy guidance, by Melbourne S. Applegate. Foreword by Joseph H. McCoy, General Secretary, Big Brother Movement, New York Association Press, 291 Broadway, New York, 1950. 124 pp. $1.75.

The author of this book has had a long and rich experience in serving as a big brother to socially maladjusted boys. He is a business man, not a professional social worker. But he has found time during an active business career to give freely of himself to boys in trouble.

The book contains a wealth of practical information on how to establish and maintain a helpful human relationship. It includes advice on handling problem situations and considers the place of the boy's family in the relationship between boy and big brother. The information and advice contained in the book grow out of a philosophy based upon deep and abiding faith in the worth of all boys and upon great respect for the individuality of each.

Recognizing the great contribution which the volunteer can make to society's efforts to help children and youth in trouble, social workers will wish that the author had given us more about the role of the volunteer as a member of the social agency team. However, the book should have real value to persons interested in serving as "friends to boys." It expresses the kind of respect for and belief in people which should be basic to the human relationships of all of us.

Richard Clendenen

• CALENDAR

Aug. 31–Sept. 7—World Federation for Mental Health. Third annual meeting. Paris, France.

Sept. 4–9—American Psychological Association. Annual meeting. State College, Pa.

Sept. 5–7—National Council on Family Relations. Annual conference. Denver, Colo.

Sept. 18–21—American Hospital Association. Annual convention. Atlantic City, N. J.

Oct. 2–6—National Recreation Congress. Thirty-second annual meeting. Cleveland, Ohio.

Oct. 7–11—National Conference of Juvenile Agencies. Forty-seventh annual meeting. St. Louis, Mo.

Oct. 9–12—American Legion. Thirty-second annual national convention. Los Angeles, Calif.

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> *". . . a child comes to school with his mind clothed in a body; with a tangled web of emotional reactions which neither he, nor anyone else, fully comprehends; with social drives which will make him or break him, depending upon the understanding he receives both at school and at home; with conflicting hereditary and environmental forces pulling him in several directions at the same time."*
>
> —Mary Irene Atkinson, quoted in "Mary Irene Atkinson Speaking for Children," Cheney C. Jones and Gertrude Springer, editors. Parthenon Press, Nashville, Tenn., 1949.

Publications Available

Single copies of the following publications may be had without charge by writing to the Children's Bureau:

Directory, Public Training Schools for Delinquent Children. Pub. No. 264. Revised November 1949.

Moving Ahead for Children and Youth; program of the National Commission on Children and Youth. Pub. No. 329. 1949.

Guardianship; a way of fulfilling public responsibility for children. Pub. No. 330. 1949.

Essentials of Adoption Law and Procedure. Pub. No. 331. 1949.

The Confidential Nature of Birth Records. Pub. No. 332. 1949.

Services for the Child Who Is Hard of Hearing; a guide for the development of programs. Pub. No. 334. 1950.

Children Are Our Teachers; outline and suggestions for group study to be used with "Your Child From 6 to 12." Pub. No. 333. 1949.

Further Progress in Reducing Maternal and Infant Mortality; record of 1945 and 1946. Statistical Series No 4. 1949.

Homemaker Service in the United States and Canada; a directory of agencies. 1950.

1947 Chart Book; infant and childhood mortality, maternal mortality, natality. 1949.

A State Program for Staff Development in Child Welfare. 1949.

Training House Parents. 1949.

Trends and Developments in Public Child Welfare Services. Child Welfare Reports No. 4. May 1949.

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BETTER HEALTH FOR MEXICO CITY'S MOTHERS AND CHILDREN

MARIA ISABEL HERNANDEZ A. *OFELIA SANCHEZ VAZQUEZ*

IN ALL civilizations since ancient times children have been a subject of concern on the part of philosophers, educators, and genuine statesmen with a sense of responsibility for the future of their peoples.

All through the turbulent life that Mexico has lived we have always given our children as much care and protection as the times permitted.

This was true even in the days of the Aztecs. Sahagún, a trustworthy historian, relates that in the pre-Cortesian epoch the aborigines had great respect for children and treated them with utmost tenderness, extending this feeling even to the midwives who brought them into the world.

In modern times we have continued to do our best for our children, especially after the revolutionary period, 1913–15, during which all work for children suffered from upset conditions.

In 1920 the Government began to reorganize all services for children. At the same time volunteer organizations and individuals also took part in the country's efforts to improve the health of mothers and children. A newspaper campaign for this purpose, called "Pro Infancia," was launched in the columns of *El Universal.* Under the sponsorship of this newspaper the first Mexican Child Congress met in Mexico City in 1921. This Congress still meets.

In the same year the Department of Public Health began to hold an annual "Children's Week." This has developed into a real celebration. Mothers and children come to the Department's headquarters, and receive gifts; the staff members do vaccinations, distribute leaflets, and give talks on infant care.

During the first Mexican Child Congress a distinguished pediatrician suggested that the Department of Public Health establish child-health centers. This suggestion led to creation of two such centers in Mexico City.

ENTRO MATERNO INFANTIL MAXIMINO AVILA CAMACHO

In this up-to-date building, with modern equipment, is housed Mexico's model maternal and child-health center, which is described here by two members of the center's nursing staff.

A few years later the same pediatrician proposed that a Child Health Service be created in the Department of Public Health, and that more child-health centers be established, especially in the poorer quarters of the city. Both these suggestions were carried out, and by early in 1930 there were 14 child-health centers in the city.

An important development about this time was the formation of the National Child Welfare Association, under the patronage of Mexico's first lady, the wife of President Portes Gil. This association carries on its work under the technical direction of the Child Health Service of the Department of Public Health.

Soon the School of Puericulture was created, independently of the Department of Public Health. In order to supply the country with a greater number of physicians trained in child care chairs of pediatrics were founded in the Faculty of Medicine and in the Army Medical School. A milk-distribution center, modeled after the "Goutte de Lait" in Paris, was established to provide milk prepared under sanitary conditions to the poor infants of the city.

Today, in Mexico City, health services for mothers and children are organized as follows:

1. Preventive care is given through health centers and special maternal and child-health centers.
2. Medical care includes (*a*) hospital care; (*b*) out-patient care, given partly through the maternal and child-health centers and partly through the Children's Hospital; and (*c*) specialized medical care.
3. Social assistance includes the following services: Children's breakfasts, day care, foster-home care, nursery schools, family allowances, mothers' clubs, volunteer committees, and adoption committees.
4. Health education is given by physicians, nurses, social workers, and teachers in the various agencies.

There are now three model institutions in Mexico City: The Children's Hospital, the Soledad Orozco de Avila Camacho Health Center, and the Gen-

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Maria Isabel Hernandez A. and Ofelia Sanchez Vazquez are both on the staff of the General Maximino Avila Camacho Maternal and Child Health Center, Mexico City. Miss Hernandez is Chief of the Prenatal and Postnatal Service. Miss Sanchez Vazquez is a Pediatric Visiting Nurse. This article is a condensation of a paper given at the public-health-nursing section of the third annual meeting of the Mexican Public Health Society. The condensation was made and translated by Elisabeth Shirley Enochs, who is the Director of the Division of International Cooperation, Children's Bureau.

eral Maximino Avila Camacho Maternal and Child Health Center. The last-named is the one to which we shall pay special attention, since it was the first of its kind, with specialized staff and equipment meeting modern scientific standards.

This center was inaugurated by the President of the Republic, General Don Manuel Avila Camacho, February 17, 1946, and began operations in June of that year, with the following services: Prenatal, postnatal, polyclinic, epidemiological, social-service, and day-care service. The need was soon felt for other services to make the basic services more effective, and so a maternity service and a newborn and premature-baby service were founded; others, including a mental-health service, were planned.

The work of the prenatal service is to watch over the health of the mother and the coming infant. To this end, with the assistance of public-health nurses, the service attempts to teach the people that they should come to the center for consultation even before marriage, so that they may be assured of entering married life in good health and able to have healthy children. All attending the service are given a thorough health examination. Functional tests and laboratory analyses are made, special attention being paid to detection of venereal disease.

Persons whose tests for syphilis are positive, or doubtful, are sent to the syphilis unit, where a complete check-up is made, not only of the individual but of the family group. The public-health nurse explains to the patient the need for treatment. She also tries to convince his contacts of the need for diagnosis and treatment.

Tuberculosis work is done in cooperation with the other departments. Every patient admitted is fluoroscoped, and children are routinely given a Mantoux test and are X-rayed as necessary.

The department with which the patient is registered is asked to make the epidemiological study. When a case has been located, the whole family and the contacts are checked and the source of infection is sought; these persons are followed until the antituberculosis campaign of the Departments of Public Health and Welfare takes over.

Dr. José F. Díaz, of the health center's mental-health service, notes a child's reactions to certain toys. Dr. Díaz has studied in the United States under a grant from the Children's Bureau.

While patients are awaiting consultation a nurse gives talks on health matters, including nutrition, emphasizing that the center wishes to help them have a normal pregnancy and urging that they bring their children to the center for advice on medical care and health protection, especially feeding.

When medical examinations and laboratory tests have been completed, the women receive passes entitling them to enter the maternity hospital. Five days after delivery, if the case is a normal one, the woman is discharged, and the nurse or midwife visits her home as needed. If further medical care is required, the visiting physician is notified.

From the time of the infant's birth he is the responsibility of the pediatricians and pediatric nurses. This supervision is continued in the home, and the mother is advised as to his care and feeding. This helps to reduce the number of deaths in the first days after birth.

The pediatric service was created to keep children in good health, especially those under the supervision of the center.

Children are cared for from birth to puberty as long as they are permanent residents of the zone served by the center.

The epidemiological service is well-equipped for the prevention of communicable diseases. It is under the direction of a communicable-disease specialist and a public-health nurse. On the staff are two nurses who do immunizations and biological tests ordered by the pediatrician.

What the visiting nurses do

The visiting nurses attached to this center work with children as well as adults related to them who reside within the zone served by the center. Their activities include:

1. A health census, through which the nurses become familiar with the child's environment, taking the family as the unit. A family folder is used for recording data.
2. Immunizations.
3. Investigation, reporting, and supervision of cases of communicable diseases.
4. Cooperation in locating sources of infection and control of contacts.
5. Health education, especially with respect to prenuptial, marital, prenatal, and postnatal hygiene; health of the preschool child and of the child of school age; health of the adult; and environmental sanitation.

Public-health education is carried out by the nursing staff of the General Maximino Avila Camacho Maternal and Child Health Center, through home visits, through the prenatal service, and in the postnatal and preschool services.

FOR THE HEALTH OF THE WORLD'S CHILDREN

MARTHA M. ELIOT, M. D.

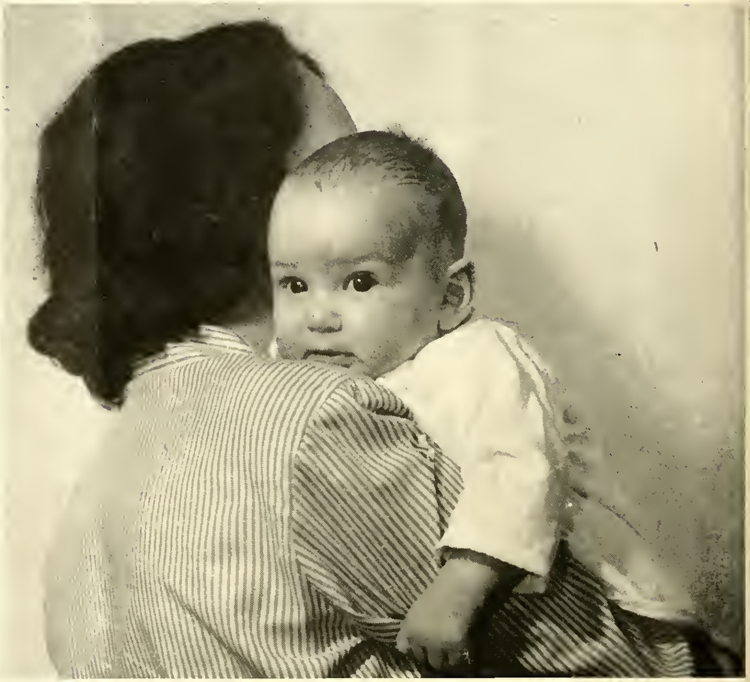
World Health Organization Stimulates Governments to Improve Maternal and Child Health

ALTHOUGH ACCURATE and reliable statistics exist only in a small number of countries, we are probably under- rather than over-estimating the actual situation today when we state that in many parts of the world one out of every four babies born alive dies in infancy. The importance of the Maternal and Child Health Program of WHO to the total work of the organization is also shown by another fact, that at least two-fifths of the world's total population consists of children and youths under 18 years of age.

The World Health Organization is promoting the health of the world's children. The programs aimed at overcoming communicable diseases and strengthening national health services are of utmost importance to children.

In all its efforts WHO keeps constantly in mind the necessity of adapting techniques and methods developed in one country to the local conditions and customs of another. It has long been known that local superstitions, taboos, and customs may seriously hamper the introduction of new health practices. WHO is seeking the advice of experts in the fields of social anthropology and health education in order to help its nurses, doctors, and other health personnel working in the field to give the best advice possible on how to mobilize the cooperation of the people for the carrying out of the necessary improvements in health measures.

WHO's direct approach to child care is carried out by the Maternal and Child Health Section of WHO, which was established in 1948. Its work is guided to a great extent by recommendations made by the first WHO Expert Committee on Maternal and Child Health, which met in Geneva, January 1949.



World Health Organization programs are of the utmost importance to mothers and children.

Perhaps the most important of all the recommendations of this Expert Committee was the one urging governments to establish official administrative divisions of maternal and child health under the direction of well-qualified and experienced specialists, and to promulgate the necessary legislation for this purpose.

Among the proposals made by the Committee I would like to mention the following as being of particular interest to this Congress:

(1) Stimulation of research and investigation of conditions affecting the well-being of children.

(2) Provision of technical information in the form of monographs and bibliographies.

(3) Sending of expert advisers and demonstration teams to countries requesting them, with emphasis on

(Continued on page 53)

Dr. Martha M. Eliot is Assistant Director-General of the World Health Organization. Before joining the WHO in 1948 she was Associate Chief of the Children's Bureau. This article is excerpted from an address made by Dr. Eliot to the Sixth International Congress on Pediatrics, held at Zurich.

A LOOK AT OUR TRAINING SCHOOLS

RICHARD CLENDENEN

THAT COMPLEX and unique institution, the training school for delinquent children (generally just called the training school) does one of the most difficult of all jobs for children. It is difficult not merely because such a school must meet the diverse needs of round-the-clock living. It is difficult chiefly because delinquent behavior grows out of a tremendous variety of human needs, which the training school must try to fulfill. Again, the training school has not had as much public understanding and support as many other types of agencies working for children. This is not surprising, for delinquent behavior violates the rights of other people, and the public demands that such behavior be curbed and controlled.

Delinquent behavior may result from a variety of causal factors. It may result from an acting out of inner conflict. With older youth, it may result from lack of support—moral and financial—by his family, from lack of supervision, and from lack of a place in society. It may result from exposure to communities where delinquent behavior is a normal way of life. However, the mere pointing out that delinquency may result from a variety of causal factors does not fully indicate how complex are the needs that boys and girls bring to the training school. Whatever the cause of the delinquency, each child is an individual who has achieved certain levels of growth and development, who has his own peculiar background of experience, his own special human relationships, his own ideas, his own loyalties, his own personality.

Many communities still lack adequate services and facilities for the care of dependent children, mentally retarded children, and children with other special physical or emotional handicaps. Even in communities where these services and facilities are available, the lack of effective diagnosis before a boy or girl is committed may bring to the training school a number of children for whom its program is unsuited. A training school serving such a community is called upon to meet an even wider range of human needs than is a training school that receives only the type of boys or girls for which it is planned.

Gradually, however, fewer children who are dependent or neglected rather than delinquent are being committed to training schools. This is what we would expect, as services to such children are improved and extended in the child's own home or community. These developments are resulting in a change in the relative number of different types of children committed to the training school—such schools now receiving a larger proportion of seriously disturbed children, and a smaller proportion of fairly stable boys and girls who help to balance the group as a whole. We are already feeling the impact of this. Facetiously but with an element of seriousness, one training-school administrator listed a need for "more stable youngsters" as a primary one in his program.

This shift in the composition of the training-school population has been slow and gradual, and its impact is not yet fully apparent in some of the less urban States. But we have little expectation of a change of direction in this trend. Indeed, as better services to children are developed in local communities, it is logical to anticipate that the training schools will be called upon to work with an increasingly large proportion of seriously disturbed children. On the whole, we have not yet faced up to the implications of this development. Certainly, it requires a regearing of our programs. If we are to meet the needs of a larger proportion of seriously disturbed boys and girls, for example, we shall have to have increased psychiatric, psychological, and case-work services.

For more flexible programs

The training-school program is complex because it must be geared to meet widely diverse needs. It is complex because its program must encompass the whole gamut of services and facilities necessary to meet the demands of 24-hour care. Meeting these demands requires flexibility in programing. There is a notable development in this country in achieving greater flexibility; in establishing what I would call better-balanced training-school programs. Differences between training-school programs naturally emerge from differences in the age and sex of the groups served, from variation in the location and financial resources of the schools, and from many other factors. In the past more basic differences resulted from the varying philosophies and concepts of function upon which the programs were based. Some of these concepts led to a lack of balance in programing, when one service or one aspect of the program was developed at the expense of others. Some schools, for example, went all-out for vocational training, trusting that the acquisition of certain vocational skills would somehow equip the majority of their youngsters with the tools necessary to work out a successful adjustment to society. Others developed strict military regimes, hoping that the rigid inculcation of habits of obedience would somehow result in conformity to the demands of organized society. More recently some schools have gone on a psychiatric

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Richard Clendenen, whose graduate degree in social work was received from the School of Applied Social Sciences, Western Reserve University, is Consultant on Training Schools in the Division of Social Services of the Children's Bureau. Mr. Clendenen gave this paper at the annual meeting of the National Association of Training Schools, which was held in association with the seventy-seventh annual meeting of the National Conference of Social Work, Atlantic City.

binge, apparently determined to treat every delinquent as a sick child.

Each of these types of programs falls short of meeting the highly diversified needs of the youth it serves. More and more the training schools are trying to make more effective use of a wide variety of training and treatment resources. One youngster may require special educational help; another a period of controlled training. One may need intensive relationship therapy; another, relief from the demands of close personal relationships. One may need to acquire vocational skills; still another may need a chance to grow and develop free from warping influences in his own home or community. To meet these needs requires the selective use of experiences in group living; of recreational activities; of educational and vocational-training programs; of religious influences; and of psychological, medical, and social services. These facts not only emphasize need of flexibility in the training-school program, but also suggest that each and every aspect of that program is a part of treatment.

Increasingly training-school administrators are emphasizing that neither clinical, nor educational, nor any other one set of services can encompass the treatment program. The way we get up, the way we go to bed, the food we eat, and, most important of all, the network of human relationships in the training school, all form a part of treatment and contribute to or detract from it. Indeed, unless the total program is oriented in terms of a common treatment philosophy, the effectiveness of any specialized service will be greatly impaired. This fact cannot be overemphasized. Truly all care is treatment.

This concept recognizes every staff member as a member of the treatment team. We should not engage a person for maintenance work routines, for example, without considering how he will influence the social growth and development of the children. The mere fact that he is absorbed in maintenance duties is no insurance that boys or girls may not identify themselves with him. Indeed, he may represent the only channel for reaching a particular child. As we recognize that each staff member is important as part of the treatment team we find we are paying more attention to staff development.

A staff-development program must rest, first of all, upon a selection process that screens out persons who cannot be successfully trained on the job. More and more in both selecting and orienting new employees we are emphasizing the fact that work in the training school will involve continuing guidance, direction, and training.

Acquiring a vocational skill may fulfill one child's need; another may require something different. To meet children's needs, training schools must use a variety of treatment resources.

We are broadening the time-honored method of orienting new employees by the simple device of assigning them to work for a period of time with an older staff member. Institutions are recognizing that good job performance grows out of a philosophy. The time and effort needed to teach fundamental concepts must be taken if an adequate staff is to be the result. The mere acquisition of techniques borrowed from another employee is not enough.

A staff-development program must include all members of the staff, though the content and scope of training may differ in degree or kind between one group of employees and another. Certain concepts, a basic philosophy, must be common to all staff. Only when this is true can we have the teamwork so essential to effective treatment. We have learned the lesson well that one employee may in a very brief and limited contact undo the carefully planned work of many others.

Good supervision for staff is getting more attention too. We are adding more administrative personnel to training-school staffs. This development recognizes that adequate supervision is time-consuming and that it consists of much more than a job-checking process. Its goal is to aid the supervised person to grow and develop on the job. Through regular conferences each employee is helped to evaluate his own job performance and to gain understanding and insight into both the dynamics of the job and his own reactions to its duties.

During the past year a large number of training schools have begun, or extended, in-service training courses for all or part of staff. These courses have ranged from 1-, 2-, or 3-day institutes to year-round classes. An example of the longer training period is an intensive course provided for cottage personnel in a training school in the Middle West. In an adjacent State another school established a field-work unit for graduate social-work students, a project that required the cooperative efforts of the training school and the school of social work, and of the State welfare department, which pays the salary of the supervisor of the students.

The training school's effectiveness, however, cannot be measured entirely in terms of its internal services, for its program is affected by the services of many other agencies. In selecting children to enter the school, for example, an important role is played by the court. Again, the intake will be affected by the work of agencies providing foster-home care, when they accept children who might otherwise be placed in a training school. After children leave a training school, they need various after-care services to help them adjust to the community. In some States these services are provided by the training school itself, but in many they are provided by various other agencies.

Teamwork needed

Each of these programs, including the training school, is in some measure supported by the others. Each program is adversely affected when there are gaps in supporting services. These facts show the need for close cooperation among the agencies involved. They also point to the need for broad social planning in relation to all socially disadvantaged children. This is a problem that reaches beyond the training school, but one in which the training school has a vital stake. Unless workers professionally knowledgeable carry continuing responsibility for such planning, others less qualified will do it for us. We cannot afford to limit our concern to the particular program we administer.

In no community in this country is there a fully adequate and comprehensive program of services for socially disadvantaged children, including delinquents, even though committees concerned with broad social planning are or have been active in a number of States. These bodies are trying to identify the several services required for a comprehensive program and to find ways to relate the services more effectively.

In several States the results of these activities are taking their most dramatic form in proposals for administrative reorganization of the services involved. I shall not argue here for or against any particular reorganization plan. Whether or not some administrative reorganization is desirable, or necessary, will depend upon the specific situation in a State or community. I must point out, however, that need for sweeping administrative reorganization of services may result from our own failure to plan broadly in relation to the needs of children.

Unless we develop sound working relationships between agencies giving services to children, unless we move together in developing a broad, comprehensive program of services, thorough administrative reorganization of our services may be the only means to achieve these ends.

Most commonly, proposals for administrative reorganization of services, including the training schools, are taking one of three forms:

One proposal is to place training schools for delinquents within the administrative structure of the State welfare department, the department that is responsible for many services for other socially disadvantaged children.

The second is to group these schools under a single governing board, which may also be given responsibility for administering some additional services in behalf of all the schools.

The third is to create a new department of government charged with administering all existing services for delinquent children. This plan, generally referred to as a youth authority, usually contemplates the establishment of certain new services.

I have said that I would not argue here for or against any particular reorganization plan. The plan adopted should be patterned to best meet the needs of a specific situation in a given geographical area. These needs vary so widely that theoretical arguments for or against a specific plan seem meaningless.

Administrative reorganization, of course, may bring certain gains. A combining of resources by several training schools may enable them to command jointly certain services which individually they could not support. If a single administrative agency is responsible for the supervision or direction of the schools the services of several agencies may be geared more effectively as well as certain duplications eliminated. It may be that no agency within a given State is now organized to establish necessary new services, or in a position to establish them. However, if a plan for administrative reorganization is to be effective, is to make a positive contribution to the welfare of children and youth, several principles should be observed.

We must recognize, for example, that no mere reorganization plan will meet all the problems of the training school or of any other service. It will not automatically bring forth a larger supply of qualified personnel or increased financial support. It will not spontaneously fill gaps in present services. These are basic problems for which there are no easy answers. To contend that a reorganization plan will solve them invites public disillusionment.

I have mentioned the close functional relationships which the training-school program bears to several other services. The training school cannot stand alone. Any plan to reorganize a portion of these services must recognize these relationships. It must further them and build upon them. It must gear into the pattern of present services, a pattern which varies from community to community. Establishment of a new agency or extension of an old one that cuts across the functions of several other agencies may result in competitive rather than coordinated services.

There is danger, too, that in our efforts to coordinate, relate, or integrate services we may lose sight of the identity of each. This danger is increased when the training-school programs are administratively merged with large multifunctional agencies that carry responsibilities for other programs besides services to children, such as the public-assistance programs in State welfare departments.

Training school is complex

The training school represents a highly specialized service. Within its program youngsters should find a secure and rewarding way of life. If they are to find this, they must find satisfying human relationships, a variety of educational opportunities, and good physical care. This requires many social, medical, and educational services. These services must be geared to the highly diverse individual needs of the youngsters it serves. And while all this is going on the training school is required to take fairly substantial measures to maintain physical custody of its wards.

Indeed, a training school is more than a State service. It is a physical part of the community in which it is located. This makes it more accessible to public scrutiny than are many related services. Also, the occasional and inevitable forays upon the community by boys or girls from a training school intensify public concern and criticism. Needless to say, the training-school program requires highly skilled administration, as well as public understanding and support. It cannot be administered from a distantly located central office. Nor will properly qualified administrators be attracted to a position having the status of errand boy. Successful administration of a training school is a full-time job requiring a high degree of skill, imagination, and patience. If this job is to be done successfully, it must include large responsibilities for the direction of staff and program. An advisory body for each school, concerned only with this school program and working directly with its administrator, may be helpful in giving guidance to its program and in establishing and maintaining public understanding and support. A reorganization plan must recognize these basic facts.

Some forward steps taken

I have said that these reorganization plans have grown out of efforts to develop better-related and more comprehensive programs of services. To what extent have such plans, when adopted, achieved these ends? Certainly, gains have been made. In some States where the training schools had been seriously subject to partisan politics, reorganization has placed the schools under a State civil-service system or, at least, under a stabilized nonpolitical board of control. Some new and extended services have been established. Notable in this area are psychological-testing services and parole or aftercare services that are shared by two or more State training schools.

A few of the reorganization plans adopted contemplate (1) a thorough study and diagnosis of each child after he has been committed and (2) referral to the facilities and services that best meet his individual needs. In no State, to my knowledge, have adequate diagnostic procedures yet been developed in connection with this plan. No State has available the battery of services and facilities needed to make the plan fully operative. The reasons for this are clear. First of all, the highly trained personnel necessary to man these services are limited and difficult to secure. Secondly, the services planned are expensive and require larger appropriations than have been available.

Unless enough personnel are available to provide clinic services—psychological, social, and medical—both for the training schools and for a central reception and diagnostic unit, I question whether such personnel should be concentrated in the latter facility. Study of a child is a continuing process. And for good treatment the clinical staff and other personnel in the training school need to get together daily.

If children are to find a secure and rewarding way of life they must have not only good physical care, but also satisfying human relationships and a variety of educational opportunities.

We need more treatment facilities

One further word about the development of facilities. Much has been said in the past few years about establishment of small treatment facilities specially designed for treatment of the emotionally disturbed delinquent child. I have heard papers that would give a visitor from Mars the impression that such facilities are an accomplished fact. Such is not the case. In only 1 of the 48 States has such a facility been established under public auspices. A few other States have developed new facilities for the care of the older and more aggressive juvenile offenders.

However, a number of new training-school programs, designed either to serve a previously unserved racial group of youngsters or to reduce the load on existing facilities, have been established. Between 15 and 20 new State facilities have been added within the last 10 years. Many others have been created under private auspices, including boys' ranches, many of which have been established in the Southwest.

Workers in the training-school field have long emphasized that delinquency is a problem that must eventually be solved in the homes and local communities. Present demands on the training schools and on other services for socially maladjusted children do not show that we are approaching that goal. Nor is there apparent reason to believe that we shall during the next few decades. If this is true, the training

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ENCOURAGING INITIATIVE IN CONVALESCENT CHILDREN

MAREE BROWER

ONE DANGER for a child in a long illness and convalescence is that he may begin to feel dependent. His stay in institutions may lessen his initiative because he gets so much satisfaction from being ministered to constantly. He may become so used to the protective atmosphere of the hospital that he dreads discharge, when he will have to go back to his family and to the competition of his usual activities. Many children with handicapping conditions who are in hospitals or convalescent homes must face the disturbing future—life at home with these physical limitations. What will it be like? he wonders.

His fears may be increased by psychological problems. Children need, wherever they are, a background of emotional security created by affection, and wise, understanding attention. This background may be difficult to provide in an institution. Separation from his family may make a child very unhappy, especially if his parents have failed to prepare him for the separation or to make him feel that they love him, or if they actually do not love him.

A child in a hospital may feel out of touch with the outside world; he has lost, temporarily, the familiar support of family life. A recreational program that brings children together in groups should be able to provide some of the warmth of spirit that the child is missing. Appreciation of him without reservation, shown by a group leader and by other children, may create to some extent a sense of security—the flavor of a family group.

The setting of my work as a student group leader, which was supervised by Professor Raymond Fisher, is Rainbow Hospital, a convalescent institution with a capacity to care for 100 children. Founded in a cottage more than 60 years ago, Rainbow is now housed in a modern, well-equipped building. Around it are 18 acres of gardens, playgrounds, and woods.

Rainbow is in a group of hospitals affiliated with Western Reserve University School of Medicine, closely integrated with them in administration and services.

The hospital, which is for relatively long convalescence, receives funds through Cleveland's community chest but it is also endowed. Few of the families can afford the full amount of the fee set for care but they may receive help from various sources to meet the cost.

Four teachers from the public schools hold classes which each young patient of school age attends for 2 hours a day. Tutors are brought in when necessary. The hospital has a large library for children, a television set, and motion-picture equipment. Well-known entertainers who want to do something for crippled children occasionally put on programs.

How recreation can be coordinated with medical, nursing, and social case-work planning for young patients who are getting well is the subject of a thesis presented by Maree Brower to the School of Applied Social Sciences of Western Reserve University as part of her work toward the degree of Master of Science in Social Administration.

Miss Brower's thesis describes an experimental program she was assigned to carry out on part time as a second-year group-work student during the school year of 1947–48. Its setting was Rainbow Hospital in Cleveland, an institution for convalescent boys and girls. Miss Brower was assigned to give the children play activities and, more important, a group experience that would be satisfying to them while they were in the hospital and that might help to make easier their change from hospital to outside world.

For THE CHILD Miss Brower has condensed her report on what she considers the focal point of her work. That is the development among the children of a representative steering committee. Building this committee was a means of helping the young patients learn to plan and carry out play activities on their own initiative.

While I was working out a recreational program at Rainbow, a storytelling group of volunteers, two Scout leaders—boys' and girls'—and a volunteer ceramics teacher carried on programs independently of mine.

When I began my part-time work with the children at Rainbow Hospital as a second-year student specializing in group work, a big need seemed to me to stand out. This was the need to get the children interested in doing some of their own planning for recreation. Because of the great appeal that a convalescent home for crippled children has for the public, much is done for the boys and girls by outside groups in the way of gifts, programs, and parties. As a result, an attitude of dependency had been fostered among the youngsters at Rainbow. Everything given or done for them they had come to accept as their due and, logically enough, had advanced to the point of demanding more. This attitude came out very strongly when I tried to interest the children in helping to plan their Halloween party but received the response, "Let the hospital do it."

So it came about that I was to encourage the formation of a steering committee of young patients. Such a committee could do more than plan activities; it might also serve as a ventilation point for some of the feelings of the children about being in the hospital. The founding and building of this committee was, I believe, the real focus of the experimental group-work program at Rainbow. Around the activities of this committee developed most of the accomplishments that were discernible at the end of the year.

How to start it? How to interest the youngsters in doing some of their own planning? How to explain the purpose of a steering committee to them? If they did show an interest when I explained it, how should the committee members be chosen—by selection or by actual elections held on the wards?

I talked with the children about a committee whenever I got a good chance, on the wards, in the playgrounds, and in the recreation room. I tried to picture the committee as a sort of city or community council—the children in the hospital would be the community and the committee would be their council, on which they would have their ward representatives. Such a council could bring together all the ideas the girls and boys had of what they would like to do and then plan the doing.

At first I was uncertain whether the children were ready to hold elections. I could not tell whether they would be able to select as their representatives boys and girls who could get something started. At the time, the morale on the wards was low; criticism by the children of the hospital and its staff was severe. The children seemed to have no feeling of closeness with one another for any reason, no sense of loyalty toward the hospital as a whole or toward any members of the staff. Perhaps a steering committee could arouse some group feeling.

An election seemed to me to be the best way to form a committee, because of its basic democratic value and its interest-provoking value. It seemed wise to confine the election to the two wards for older children (those over 10 years) but the committee would represent the young children also. Three boys and three girls, then, were to be elected from the two "older" wards.

Right away the idea of an election for representatives on a committee caught on; interest ran high. The children sensed that members elected would be important among their fellow patients. As I talked with the children about any matter, I tried to say something about the qualities to look for in selecting representatives—having good ideas and a willingness to get down to business and to work until a thing was finished. On the whole the children made their choices well. The first six members elected were obviously natural leaders; and the other boys and girls, who were not elected, seemed to recognize this fact.

The children understood that members were elected for a certain length of time, not specified however, after which other children would be chosen in new elections. But the rapid turn-over caused by discharges from the hospital of members of the committee brought about many vacancies at first. In less than 4 months, 16 different children served on the committee. These 16 had a variety of handicapping conditions. Some were able to walk; others came to the meetings in carts, wheel chairs, or beds.

During a long period of illness and convalescence a child may begin to depend too much upon others. Such children need special encouragement if they are to regain their initiative.

As vacancies occurred they were filled through elections held by the ward to be represented, in many cases when I was not there or even without a suggestion from me. The youngsters often learned before I did of the impending discharge of a committee member and they would tell me that another election must soon be held. The elections were presided over by members left on the wards at the time. The elections continued to arouse great interest.

Meeting together means a lot

In 4 months the committee met 15 times. During that time I could see definite progress in the group. One indication of this was that interest in the committee continued, not only on the part of members but of potential members. The members' interest seemed to hold because although the meetings were for business the children thought of them as social occasions also. That was because membership meant belonging to a small, intimate group different in atmosphere from their living groups and from their classroom groups. Besides, they met in the evening and left their wards for the meetings. Getting off the wards at night was very special indeed. Refreshments were always served. The committee was a mixed group—three boys and three girls—a fact very important to adolescents.

Right at the first I had to do a good deal of the planning. But the children picked up suggestions rather well and finally came to initiating a few ideas themselves. The first project undertaken by the committee was a Thanksgiving party, although as recently as Halloween the children had been unwilling to take any initiative in such planning. Now the steering committee was willing to plan this party and to work on it. (Undoubtedly this response was mainly to gain my approval.) The committee agreed to be responsible for the decorations and for planning and running the games.

The committee asked at once to have the party in the evening, "when parties should be held." This was impossible to arrange but the children of the committee accepted the disappointment philosophically and went on with their plans.

The steering committee decided to give two parties at the same time, one for the younger children and one for the older ones. It would ask to have the help of nurses' aides to manage the party for the little ones, but the committee agreed to help direct the games for both parties. The members began planning the games and practicing them in committee meetings.

The party time came. The decorations were few and sketchy but they were all the work of committee members or of other patients whose help they sought. All members arrived a good half-hour before the appointed time. They seemed excited and nervous. The boys were spruced up, their hair slicked back as never before. Each member checked and rechecked his games. The two boys who had volunteered to receive the guests stood in the doorway for 15 minutes before anyone was scheduled to come, with pins and name cards ready, discussing exactly how they were supposed to greet guests and to pin on names. One of the girls said that the committee members themselves should have badges. So they printed "Committee Member" on long strips of construction paper and pinned them on each of the six.

The guests assembled. As it came time for each game, I would say whose turn it was, and that committee member would direct his game. He was supposed to wait until he had everyone's attention and then explain slowly what the children were to do. Most of the members followed this plan well. I did have to help several times in clarifying instructions. Most important, the enthusiasm of the committee seemed to transmit itself to the other youngsters so that almost all entered into the games with spirit.

Two of the committee girls helped with the "little kids' party," remembering to leave their own party to run games for the younger ones. The other four members got too much interested in their own party to remember.

Everyone seemed to have a good time. Children exclaimed over the accomplishments of the steering committee. Why, the committee ran the games! The six members were frankly pleased. They seemed to feel the satisfaction one gets from assuming responsibility and carrying it out. Their huge badges seemed to show the prestige they felt in "belonging."

Taking care of the games

The committee accepted other responsibilities during the first month of work. New games, ordered for my use in the program, began to arrive. How should they be cared for when I was not in the hospital so that they would be safe, yet available to the children? Previously, games left on the wards had been broken or parts had been lost. If they were locked safely in the playroom closet during my absence, however, they would be useless.

The steering committee took up this problem. Members showed that they appreciated the difficulties and wanted to help. They wanted the games to be used every day, but they were a bit afraid to pledge their safety. They knew too well how many misfortunes could come to games and toys. Finally two members volunteered to check the games out and in on the days when I was not there, one on the boys' ward and one on the girls' ward. But they asked me to arrange for locks for the game cabinets.

From then on, the committee selected one member from each ward to take charge of the games. They seemed to achieve a certain prestige from doing this job, which the nonmember children freely acknowledged to be one for the committee. The same plan was worked out for the new magazines that had been ordered. In addition, the committee kept track of the magazines that the children liked best.

At Christmas time the committee helped make a decision. All the children were making gifts from materials supplied by the hospital. The committee had the task of keeping lists on each ward of materials needed by each child. Gift making became so popular, however, that the expense went way over expectations. The committee discussed the problem. Quite obviously some limitation was in order. I asked what the members thought about limiting each child to free materials for two presents. They could buy materials for additional presents. One girl spoke up, apparently for all but one member, a boy who at first remained silent. The girl thought that the hospital should supply all the material necessary. I tried to encourage more discussion. Was the hospital obliged to supply more than medicine, food, and such necessities? The children persisted. Their families were paying for their care and the hospital should give them stuff for Christmas presents. Suddenly the silent boy spoke up, to disagree. He himself would pay for extra material; that was only right. His attitude turned the tide. Material for two free gifts was all right.

"Can you tell the other children about this decision?" I asked. They said they could, and they did it well. When next I went on the wards, I found that most of the children understood that they were each entitled to material sufficient for two presents only.

Then came the chess and checkers tournaments. I had noticed much interest on the boys' ward in these two games. I began to talk about a tournament. Interest spread quickly to the girls' ward. A girl member brought the idea before the committee. It took on the job of running a checkers tournament for girls and one for boys, the winners to play for the championship. The chess tournament was to be for the boys only.

The committee grows in stature

About this time the committee members were bothered to find that they could not remember from meeting to meeting what old business they had to consider. They decided they needed one officer, a secretary. At earlier meetings I had suggested having a member take minutes, but the committee was not interested until it saw that a secretary could really help. Then it elected one.

After Christmas, the committee undertook to see that thank-you letters were written to people outside the hospital who had sent presents. Then the two tournaments were over and they wondered how to announce the names of the winners. I asked, "How about a newspaper?" They were delighted with that idea and began at once to select subjects for articles. They had already begun to consider giving a Valentine party, and they set the date for the first issue of the paper at a time when they could report this party.

But before the party or the newspaper debut, a decision had to be made about the length of a member's term on the committee. No election had been held on the boys' ward for some time and several boys wanted to run for office. When the matter was first brought up at a meeting, each member took the discussion as a personal criticism. Finally, however, they understood that it had always been intended that the terms be limited. I suggested a 12-week term, with elections held on the wards every 4 weeks to replace one member. The committee decided that that plan would be all right—if members really had to change. They obviously did not want to, so much group feeling had developed among them.

In getting out their newspaper, the committee worked with a teacher who had supervised newspapers in the hospital in earlier years. Some of the articles were written for class; others were requested by the committee. Members worked on collecting articles, setting up the dummy sheet, running off the pages, stapling them, coloring the front page, and distributing copies on the wards.

As the student leader of this program, I believe that committee membership helped some of the children. They seemed better able to adjust themselves to their handicaps and to group life. Of course I do not claim that progress was startling. Nor would I imply that group experience alone was responsible for any child's improvement. I can think of two girls, however, whose reactions illustrate what happened to several committee members. These girls seemed happier for having belonged to the committee and this happiness carried over into other parts of their hospital lives.

A shy child enjoys membership

There was Mary, a child who obviously needed affection and recognition. She came from a fatherless family of many misfortunes. Her disease, rheumatoid arthritis, very crippling and painful, confined her to her bed or cart nearly all of the time. Mary had two abilities, drawing and singing, but was too withdrawn into herself to take part in games, fearing competition. The child showed great friendliness toward me. Once she told me sadly that she felt sure the others on the ward did not like her.

Mary's election to the committee was a lucky break because she seemed happily convinced that if she had been disliked she would not have been elected. Perhaps for Mary as much as for any committee member, this small group served as a substitute family, with the one adult, me, in the role of mother, and the other children as brothers and sisters.

On the night before Mary left for home, she first decided not to go to the committee meeting. Then she made an excuse to go late. At the end, the little girl took me aside and tried to say, in spite of her shyness and her emotion, what being on the committee had meant to her.

Another girl, Alice, was Mary's opposite in behavior; she was too outspoken. When she came to Rainbow she was a ringleader in much that the hospital staff considered "bad." She was loud and domineering, and she talked back to nurses and aides. Of course, she was bidding for attention; she was expressing her feeling about her illness.

"You know I'll get it done"

Soon after Alice was elected to the committee, she began to use her energy in new directions. When she saw that she gained prestige by assuming responsibility, she volunteered for extra chores and carried them through. She had many ideas and was not afraid to voice them in meetings. I tried to help her to work with the rest of the group so that she had her chance to feel useful but also freely gave others their chances to show what they could do. She angled for open approval, saying to me, "You know I'll get it done," and beaming at my answer, "Of course you will." Once when she was punished by being kept from committee meetings, she took even this great hardship better than she had taken earlier discipline.

While I was carrying on these activities, I had chances to talk with nurses and other staff members about the committee's work. Most of the nurses and aides seemed to realize that the patients should take more responsibility. But a few of them thought this might be brought about by strict rules, such as that the children make their beds and keep the wards picked up. Sometimes the misbehavior of a group of children that had some connection with the recreation program, and had caused a nurse great inconvenience, gave me a chance to talk with her about a remedy. Was it a matter, did she think, that the committee might discuss and perhaps act on? She usually thought so. When the system of checking out games was started, I gave the names of the committee members in charge to the nurses, asking them to help the children carry through their duties.

As I look back over the meetings, I can see a definite flow of program interest. Originally, the members saw their purpose as putting on parties. Later, their idea of the reason for having the committee broadened. From "big" seasonal celebrations, attention turned to directing ward activities. More enthusiasm carried over from a meeting through the week. More and more, the members saw themselves as being in a position of responsibility on the wards. The privileges they had as committee members they guarded carefully; for instance, permission to leave the wards in the evening for their meetings. Deciding to keep minutes was a step toward greater self-direction. In planning to get out a newspaper, the committee showed willingness to attempt something that required sustained interest and regular work.

Members seemed to profit from being together in the meetings and from feeling able to talk freely before an adult. The need of these young people to be with companions of the opposite sex of their own age was met in a small way by these gatherings. Also another adolescent need was partly met—for more and more independence. Of course, I had to check up during the week and to remind some members of their commitments. But that would be true of any group of children of that age; they want to be independent, yet fear to get too far beyond the guiding hand of an older person.

One reason committee members tried to carry through plans they made may well have been a desire to gain my approval. I was a grown-up, they realized, who thought them capable of taking responsibility. Lack of affection at home may have made more pressing for several children the need for gaining the appreciation and approval of some adult.

Not for themselves only

Committee membership may have given the children, indirectly, a little preparation for citizenship, but that is difficult to judge. The ward elections may have taught the boys and girls something about democratic methods of doing things. Duties became theirs because they were elected to office. They planned and acted not just for themselves but for other children whom they represented. Truly democratic government. When these children grow older they may see this, looking back to their convalescent days at Rainbow.

Reprints in about 6 weeks

TRAINING SCHOOLS

(*Continued from page 48*)

schools of this Nation may be confronted with very serious problems of overloading within the next few years, when our increased child population reaches the ages served by the training schools.

It is estimated that the number of children in the public training schools declined about 29 percent between 1933 and 1947. At that time a decline was to be expected, as intake became more selective. However, another factor—seldom mentioned—that may have been important in accounting for part of this decline, is that the number of children between the ages of 10 and 17 years in the general population decreased 11 percent during the same period. During World War II the birth rate increased sharply. This will not greatly change the number of children 10 through 17 years of age until 1953. By 1960, it is estimated the number will be approximately 50 percent greater than it is now, and the impact upon the training-school programs may be severe.

Many other trends and developments could and should be noted, but space does not permit. I have not talked about the shift that has taken place on the West coast, away from the cottage-parent plan and toward a counselor system. Nor have I commented on some of the experimental projects being carried on in several schools. However, all the developments that I have been able to include, plus the many that I have not, add up to a state of healthy activity, growth, and development. We are not stagnating. True, individual schools are lagging, as will always be the case. But a more significant number are constantly seeking ways and means to improve their programs to the end that children may be better equipped to become adequate citizens. So long as this remains true, so long as we attempt to examine objectively what we are doing and evaluate it, so long as we refuse to become defensive of current programs and practices, the training schools will continue to make an important contribution to the development of American children and youth.

Reprints in about 6 weeks

HEALTH OF WORLD'S CHILDREN

(*Continued from page 44*)

the needs of underdeveloped countries.

(4) Expansion of the existing fellowship and training program, with emphasis on the training of nurses, nurses' aides, midwives, nutritionists, and health educators, as well as physicians.

(5) Incorporation of teaching in mental health in every program of study for fellows in maternal and child health.

(6) Establishment of a special health-education service within WHO.

(7) Cooperation with UNICEF in the organization of maternity services and all kinds of child-health clinics, including clinics for handicapped children and child-guidance clinics, and the extension of mass immunization campaigns.

In the beginning of its child-health work WHO undertook a number of general surveys to determine the basic requirements of countries, which have been carried out by WHO maternal and child-care consultants in Malaya, Borneo, Singapore, Hongkong, the Philippines, Thailand, Afghanistan, Egypt, and India. These general surveys are useful in providing background information, and are being continued as indicated.

In the eastern Mediterranean region the maternal and child-health adviser is at present reviewing the child-health problems in a number of countries in order to advise on how the most pressing needs can be met in each country. Attention is concentrated on particular problems, depending on the stage of development of the child-health services and how they can be best organized in local areas. In some countries emphasis must first be placed on training medical and nursing personnel. In others, problems of nutrition and infant care, including even the care of prematurely born babies, come first, or immunization against smallpox and diphtheria or whooping cough. In still others emphasis must be placed on tuberculosis in childhood and the use of streptomycin in tuberculous meningitis, or on the use of penicillin in the treatment of syphilis and yaws. As a result of such special studies pointing out specific needs, much assistance has been given to governments by joint WHO/UNICEF planning and action, WHO providing the technical advice and assistance, UNICEF the supplies and equipment.

In addition to such joint activities with UNICEF, WHO provides at the request of governments many special consultation services that affect child health. Thus, Chile and India have had consultation from medical, nursing, and physical-therapy experts in the treatment of poliomyelitis and its aftercare; Finland in discovering the reason for an unexplained increase in infant deaths; the Philippine Islands in establishing its child-guidance program; Venezuela and Yugoslavia in developing a mental-health program, including child guidance; and so on.

To sum up, WHO is a medium through which people can help people, nations can assist nations in attaining health. In the final analysis, WHO will be what all of you here want it to be. In this sense the fate of the world's children, to which the Sixth International Congress of Pediatrics is devoted, will be influenced by the choice each of you is bound to make, by the support that each of you can give. I am confident that, once there is understanding as to what can be accomplished for the health of children through WHO, there will be no lack of support, and that year by year children will come into the world more fit and will grow to a healthier maturity because of your efforts and those of WHO.

• IN THE NEWS

A Grass-Roots Program for Children Develops

The Midcentury White House Conference on Children and Youth is reversing procedures of the four previous White House Conferences. It is beginning in local neighborhoods—not in Washington. When the 5,000 delegates gather in Washington in December they will not expect merely to "take home" a program developed in the formal meetings. They will also share with each other the experiences they have gained in more than a year of preparatory work in their own home towns and counties. And their goal will be improved local services, services that are tailor-made to meet their own unique, neighborhood needs.

Already, 150 State-wide meetings have been held throughout the Nation. Nearly 1,000 counties have formed White House Conference committees. Fifty thousand lay citizens are now engaged in Conference projects. Fifteen thousand specialists and consultants are working with the State and local committees.

Reports now rolling in from State and county committees all over the Nation repeat the same theme: "We're doing it ourselves!" "Guides and suggestions from the national committee are fine; we welcome them; but we change and adjust them to meet our local needs—it's OUR program."

This probably explains the rapid growth of neighborhood and county organizations devoting their major effort to the conference; likewise the enthusiasm with which they tackle their jobs.

"Bringing fact finding to fruition of action is the end to which the people in our workshop are dedicated almost to a point of religious fervor," reported one Ohio workshop chairman.

In Colorado, a late spring blizzard was raging when a regional meeting was scheduled. The roads were slow and dangerous, but 135 people from 21 counties attended. This persistence is one of the reasons that fact finding has not only been completed in 10 Colorado counties, but public meetings have been held to present the facts and to win citizen support for doing something about them. Exhibits at State and county fairs, in many areas, will be used to display the results of local fact-finding programs and to enlist still more recruits for local action on behalf of children. As in every other aspect of the program, the "typical" conference fair booth does not exist—they are as varied as the activities that produced them.

In the careful survey of every aspect of child life, many surprises occur. Conference workers in one State, for example, discovered that the indenture of children was still legal. True, they found no evidence that any child, in recent years, had been bound out for his labor—but, legally, it could still be done! In another State, convinced that the problems of children of migrant laborers were none of their concern, the workers discovered that they had several hundred such children with problems quite as serious as those in States where migrant labor is a recognized part of the economy.

Literally hundreds of meetings have been held in several States. Questionnaires, as thick as the telephone directories of many towns and villages, have been sent to teachers, housewives, businessmen and laborers. Young people have formed their own committees and developed their own questionnaires. Everyone is getting a chance to give his views about what can and should be done to improve children's chances for growing up into well-adjusted, responsible, democratic citizens.

The answers are piling up; they are being studied; plans are being made. Just as each previous conference has had some major achievement to which subsequent generations have pointed with pride, so the Midcentury White House Conference promises to become famed as the "grass-roots program for children and youth," the program aimed at helping to provide the conditions to enable our children to live as happy and useful citizens.

To Study Hospital Food Services

To give in-service training to dietitian consultants, nutritionists, and dietitians providing advisory consultant service to dietary departments of hospitals and institutions, the American Hospital Association will conduct an institute and workshop on planning and operating hospital and institution food services October 9–13, at Washington, D. C. Sponsoring organizations are the Children's Bureau and the Public Health Service, both of the Federal Security Agency, and the American Dietetic Association.

For the Cerebral-Palsied

A 2-week institute in cerebral palsy, for qualified physicians, nurses, physical, occupational and speech therapists, social-service and guidance workers, and teachers, has been announced by Dr. Philip D. Wilson, President of the Coordinating Council for Cerebral Palsy in New York City, Inc., 270 Park Avenue, New York City. The institute will begin Monday, November 6.

• FOR YOUR BOOKSHELF

THE HANDICAPPED CHILD: a guide for parents. By Edith M. Stern with Elsa Castendyck. A. A. Wyn, Inc. New York, 1950. 179 pp. $2.

Despite the best efforts of the medical profession, there continue to be parents whose children are handicapped either in their senses or in their limbs. For these parents, devoid as they often are of the joy of seeing their child growing up normally, and plagued by fears and feelings of guilt, Mrs. Stern and Miss Castendyck have written this book. As they themselves point out, it is not a general manual on child care, nor is it encyclopedic concerning illnesses, but it stresses "the fact that good principles of child rearing apply equally to the normal and the handicapped."

With an extremely frank survey of the feelings of the parents and an appreciation of what their handicapped child means to them, the authors have tried to relieve the unnecessary guilt of those parents who feel themselves at fault. Very sensibly they point out that the parents' feeling of guilt often results in their smothering the child with attention, or else in being overly demanding. But they also bring out well how human and usual it is for parents to become overwhelmed with the situation of having a handicapped child. Finally they point out the routes that parents can take to get help both for themselves and for the child.

After this general statement, the book is divided into chapters, according to handicapping conditions. These conditions include not only crippling but also cerebral palsy, epilepsy, poor eyesight, impaired hearing, and low mentality. There is a final chapter on chronic illness, particularly stressing rheumatic fever. Each of these chapters provides concrete advice about the particular condition and offers valuable suggestions as to where the parents may turn. It should not be inferred that the book merely consoles, or attempts to minimize the parents' feelings or the child's handicaps. It tries to make more clear the crippling aspects of the handicapped, both physically and emotionally, and to help parents clarify their feelings about the child as they work to help him.

While it is obviously impossible to solve all the problems faced by parents whose children are handicapped, this book, stressing as it does the underlying principles of good child care, can be of real assistance and support.

Henry H. Work, M. D.

YOUR CHILD AND OTHER PEOPLE; at home, at school, at play. By Rhoda W. Bacmeister. Little, Brown & Co., Boston, 1950. 299 pp. $3.

If the title of Mrs. Bacmeister's new book had included the words "social living" it might have sounded too much like a treatise to attract the majority of parents. But social living is the book's theme, and readers will find in it some very thought-provoking suggestions on the dynamic part parents can play in furthering their children's social development. The author digs right down to the roots of living in a world of people by devoting two chapters to an explanation of children's early emotional patterns. This serves as a prelude to discussions of play and playmates, of meeting the world outside, and of learning what it means to be one of a larger group. With the problems of rural mothers in mind, one is bound to feel a twinge of regret that the book seems directed almost solely to urban readers—and comfortably situated ones at that.

Mothers interested in the rapidly spreading cooperative nursery school movement will be especially grateful for Mrs. Bacmeister's practical, down-to-earth chapters on "Could we start a cooperative group?", "When neighbors share child care," and "Adjusting to school or play group." This fresh, new material will be hungrily pounced on, for up to now there has been little that those seeking help in setting up informal play groups and neighborhood nursery schools could turn to.

The book is almost a manual for cooperative groups. In addition to such important features as a chapter on learning to supervise children at play, and one on what they learn while at play, there is a good list of play materials, a discussion of the principles on which their selection should be based, and diagrams for the arrangement of play rooms and play yards. Brief lists of stories, poems, and songs for children and books for parents are also included.

The book is written in a simple, friendly style, pointed up with many illustrative real-child incidents. Each mother who reads it will feel that Mrs. Bacmeister is talking directly to her.

Marion L. Faegre

THE SELECTION AND ADMISSION OF STUDENTS IN A SCHOOL OF SOCIAL WORK, by Margaret E. Bishop. University of Pennsylvania, School of Social Work, Philadelphia, 1948. 58 pp. $1.

Every profession wishes to admit only those persons who are well suited to the work of that profession. And since educational institutions offering training for the various professions can admit only a fraction of their applicants, they have become increasingly concerned about the processes used in selection. Various ways of screening are being tried, including objective psychological tests and other methods.

A process that is succeeding in the University of Pennsylvania School of Social Work is described in this report. From the first step, when an interested person writes to inquire about the school, to the last, when an admissions committee accepts or rejects his application for admission, the aim of the various procedures is to give both the school and the applicant opportunity to know more about each other.

The author of the report, who is director of admissions and placement for the school, describes the procedures, which begin when the applicant, at his request, is sent an application blank and a series of questions. The school asks the applicant to describe his education and work experience and to tell what he has gained from his experience in relation to his purpose in applying for training in social work, as well as to state whether he wishes to enter social case work or social group work. He is asked to provide references from his supervisors, as well as information about his health, including a doctor's statement.

The director of admissions carefully studies all this written material and then invites the applicant to the school for an interview. After the interview, which is most comprehensive, and which may reveal attitudes not discoverable in the applicant's written material, comes the interviewer's report to the admissions committee, and then the committee's decision.

Throughout these procedures the school places much stress on the participation of the applicant at every step, recognizing that only through such participation can he determine for himself his interest in the profession of social work and his wish to become a part of it. Similarly the process helps the school to evaluate the ability of the applicant to relate to the school, and, accordingly, to the professional training he will receive.

The first test of the validity of any admission process is the percentage of students successfully completing their first year of training, and in the University of Pennsylvania School of Social Work this percentage is high. It would be interesting for the school to study at some point those students who did not successfully complete their first year and to look for clues to the cause of their failure that might have been noticed in the course of the admission process.

Doris Siegel

• CALENDAR

(Begins October 1)

Oct. 2–6—National Recreation Congress. Thirty-second annual meeting. Cleveland, Ohio.

Oct. 9–12—American Legion. Thirty-second annual national convention. Los Angeles, Calif.

Oct. 7–11—National Conference of Juvenile Agencies. Forty-seventh annual meeting. St. Louis, Mo.

Oct. 6–19—Third Pan American Congress on Physical Education. Montevideo, Uruguay.

Oct. 15–20—National Council of Jewish Women. Annual meeting. New York, N. Y.

Oct. 16–19—American Academy of Pediatrics. Nineteenth annual meeting. Chicago, Ill.

Oct. 16–19—National League to Promote School Attendance. Thirty-sixth annual convention. Richmond, Va.

Oct. 16–20—American Dietetic Association. Thirty-third annual meeting. Washington, D. C.

Oct. 16–20—National Safety Council. Thirty-eighth National Safety Congress and Exposition. Chicago, Ill.

Oct. 17–19—American Occupational Therapy Association. Annual meeting. Glenwood Springs, Colo.

Oct. 23–28—Association of State and Territorial Health Officers. Annual meeting. Washington, D. C.

Oct. 24—United Nations Day.

Oct. 26–28—National Society for Crippled Children and Adults. Annual meeting. Chicago, Ill.

Oct. 30–Nov. 2—American Dental Association. Ninety-first annual session. Atlantic City, N. J.

Oct. 30–Nov. 3—American Public Health Association. Seventy-eighth annual meeting. St. Louis, Mo.

Nov. 2–6—National Conference of Catholic Charities. Annual meeting. Washington, D. C.

Nov. 5–11—American Education Week. Thirtieth annual observance.

Nov. 7–10—School Food Service Association. Kansas City, Mo.

Nov. 12–18—Book Week. Thirty-second annual celebration. Information from Children's Book Council, 50 West Fifty-third Street, New York 19, N. Y.

Nov. 16–17—National Committee for Mental Hygiene. Annual conference of the National Association for Mental Health. New York, N. Y.

Nov. 16–18—National Council of Negro Women. Fifteenth annual convention. Washington, D. C.

Nov. 16–18—Family Service Association of America. Biennial meeting. New York, N. Y.

Nov. 30–Dec. 2—American Public Welfare Association. Annual Round Table Conference, featuring the organization's twentieth anniversary. Chicago, Ill.

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THE CHILD

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UNITED NATIONS DAY, 1950

24 October

To the Young People of the United Nations:

The United Nations was created 5 years ago in the name of the peoples of all member countries. That includes you. Young people, as well as adults, have a part to play in building a better world.

All peoples of the world want peace, social progress, and better standards of living. History has shown, however, that national rivalries can lead to disputes, and even wars. To prevent this, the nations of the world must plan and work together in a spirit of "give and take."

In your school and home you learn to give and take. You learn to curb selfish demands and to be a good member of your school and family. In the United Nations, member countries have the opportunity to solve their differences in the same spirit and to live as good members of a world family.

By studying the United Nations in your school and by talking about it in your home you can help bring about a real understanding of its aims and ways of working. What is discussed in homes spreads in widening circles through whole communities, and even through entire nations. In this way you, too, can do much to help spread understanding of the United Nations.

Let us all, from every nation, make a special effort during this coming year to help our countries understand each other better and work together through the United Nations. Let us all be determined that there shall be peace.

Trygve Lie

Secretary-General United Nations

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NOVEMBER 1950

A BETTER START IN LIFE

U. S. SUPERINTENDENT OF DOCUMENTS
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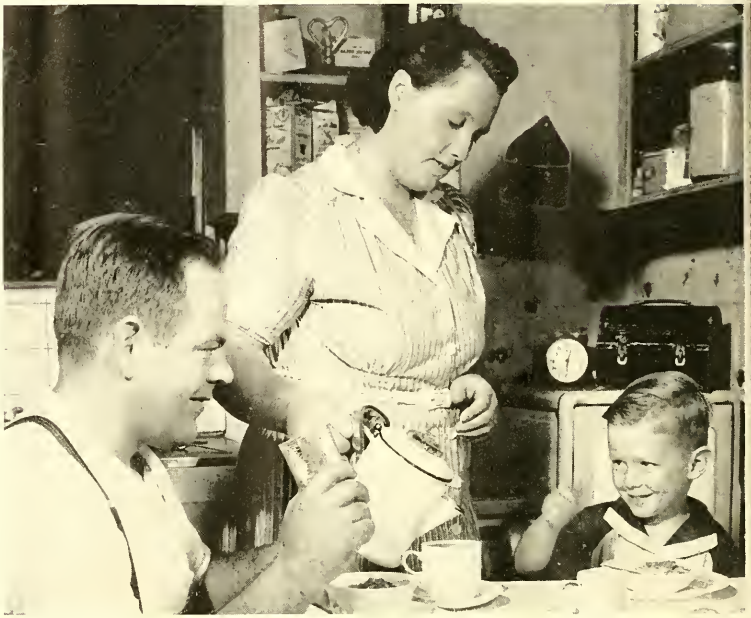
How the 1950 Amendments to the Social Security Act Benefit Children



As a result of passage of the 1950 amendments to the Social Security Act, American families can face, with increased confidence and hope, whatever emergencies lie ahead of them.

MANY THOUSANDS of children will have a greater chance for a good start in life, thanks to the 1950 amendments to the Social Security Act which became Public Law 734 when the President signed this measure on August 28.

More children are now covered, through their working fathers and mothers, under the Old Age and Survivors Insurance.

The benefits that children, as well as workers, receive under this insurance are now more liberal.

Federal contributions, under public assistance, can now go to mothers or other relatives providing homes for dependent children who previously were not entitled to such help.

Children of needy workers who are permanently and totally disabled will find life less difficult now that Federal aid can be paid to their parents, as it has been paid to the aged and the blind for the last 15 years.

Congress can now almost double its present grants to State health and welfare agencies for services to children so that more children can receive these services.

Here, in capsule, are some of the major gains children made in the 1950 amendments to the Social Security Act.

Through these amendments, the Congress once more has affirmed a basic principle of social security. "The heart of any program for social security," said the Senate report on the 1935 act, "must be the child. All parts of the Social Security Act are in a very real sense measures for the security of children."

Doctors, nurses, and all kinds of health workers have as much interest in the gains which the new law brings to children as have child-welfare workers. Putting a broader, firmer floor under family economic security can increase the chances of many children to grow as happy, healthy individuals. Giving a stronger hand to State and local services for children can open the doors of clinics, hospitals, foster homes, and other welcoming shelters to many sick, unhappy, bewildered children.

No one is claiming that all the security needs of children are met by the new law. But the new law, the culmination of years of study and thought by legislators and students of social security, writes on the statute books of the Nation new hopes and new opportunities for many needy boys and girls.

Some of these gains for children can flow out immediately in the form of larger pay checks to families. Some, like increased Federal support of children's services, will take longer to show up in the lives of children. But across the Nation, all public servants involved in the operations of social-security programs are doing everything in their power to speed the day when the full benefits of Public Law 734 can reach every eligible child.

Gains for children in Old Age and Survivors Insurance

The most important improvements in this part of the Social Security Act are those that broaden and strengthen the general provisions for all beneficiaries. Children of many workers not before protected will now get benefits.

Between 8 and 10 million additional workers are now brought under the system. These are self-employed persons, other than farmers and certain professional persons; regularly employed agricultural and domestic workers; certain public employees and workers in nonprofit organizations.

In the past, wages in all covered occupations amounting to over $3,000 a year were excluded from this insurance plan. Now, the insurance plan includes workers who earn up to $3,600 a year, which will mean higher benefits for a large number of workers and their families.

Increases in benefits, provided by the new law, naturally help children as well as their parents. Beneficiaries who have qualified for benefits in the past have had their benefits increased 77 percent on the average. Those who retire after the new amendments have been in effect a few years will get a somewhat greater increase.

Previously, the smallest amount that could be paid to any wage record was $10 a month. Under the new law, the minimum benefit payable to an insured worker is $20 a month. The only child of an insured worker, under the old plan, could receive only half of the deceased worker's benefit—or a minimum of $5 a month. Now he can receive three-fourths, or a minimum of $15 a month. If there are two or more children in the family, the extra one-fourth is distributed evenly among them.

The maximum family benefit may now be as much as $150 a month. Formerly it was $85. This will mean much to families with several children.

Formerly, a child was counted dependent on his mother and therefore entitled to insurance only if his father was neither living with him nor contributing to his support. This meant that when a disabled father lived in the home or a divorced father contributed small but regular amounts to the child's support the child could not receive insurance benefits. The new law liberalizes payment of a child's benefit on the work record of the mother. He can get benefits if his mother qualifies, even though the father has been living with the child or has been contributing small amounts to his support.

Until enactment of the 1950 amendments, an adopted child could not receive benefits if his adopting parents died within a year of the time the adoption occurred. With the 1950 amendments, an adopted child who meets all other requirements may receive benefits on his adopting parent's record even though the adoption occurred less than a year before that parent's death.

These are a few, but not all, of the changes in insurance provisions that mark the new law as a good step forward in our Nation's social-security program.

Gains for children in public assistance

Changes in the program for aid to dependent children are very important.

Heretofore checks, paid in part by the States and in part by the Federal Government, have been sent monthly for the care of needy children, but no provision was made for the mother or other relative who provided a home for the children. Since one of the principal reasons for this program is to give children a chance to grow up in their own homes, cared for by someone who cherishes them, denying payment to the mother or other caretaker was defeating the very purposes of the program. Now, Federal funds can be used to match payment to one adult relative who looks after dependent children.

Federal funds, under the old law, were available to help finance payments to needy people in only three categories; the aged, the blind, and dependent children. Now a fourth group has been added: the permanently and totally disabled. Children in these homes will feel the difference.

Under the old law, a person who was hospitalized in a public hospital was not eligible for public assistance to which the Federal Government contributed part of the cost. Now Federal funds can be used unless the patient is in a mental or a tuberculosis hospital.

An additional method of helping States pay costs of medical care for children is now possible. The Federal Government may help the State to pay the bill when the welfare agency pays the doctor, nurse, or hospital directly.

Gains for children in grants for services

From its earliest days, the Social Security Act has recognized that many children need the help of doctors, nurses, social workers, and other skilled people, as well as money payments, if they are to have real emotional and economic security. To this end, the act has authorized Congress each year to appropriate funds to be given to the States to help them extend and improve their health and welfare services for children and maternity services for mothers.

Since 1946, these annual grants have been limited to $11 million for maternal and child-health services; $7.5 million for services for crippled children; $3.5 million for child-welfare services.

The new law lifts these ceilings, starting with the fiscal year 1951–52, to $16.5 million, $15 million, and $10 million for the corresponding services. (In the present interim year, Congress has already appropriated a total of $13.2 million for maternal and child-health services; $9.975 million for crippled children's services; and $7.075 million for child-welfare services.)

None of this money is paid to children or their parents. All of it goes to official State agencies, to be used in paying the cost of child-health and child-welfare services. The great bulk of it pays the salaries of doctors, nurses, medical social workers, nutritionists, physical therapists, child-welfare workers, and other professionally skilled people serving children. Much of the money for crippled children pays the cost of medical, hospital, and convalescent care. Some of the child-welfare money will help to pay the cost of foster care for children who cannot be cared for at home, and the cost of returning to their homes in another State children who have run away.

Maternal and child-health funds go to State health departments; crippled children's funds go to State crippled children's agencies, some 31 of which are in State health departments. Child-welfare funds go to State welfare departments.

In all three programs, emphasis is given to building services in rural areas. Each State receives a flat amount for each of the three programs. The balance of the Federal funds is apportioned to the States on the basis of various factors which take into account the relative needs of States for help in serving their children.

As in the old law, to take full advantage of Federal grants for health services, States must match half of the

(*Continued on page 68*)

A RURAL COMMUNITY PLANS FOR GUIDANCE OF ITS BOYS AND GIRLS

AMBER ARTHUN WARBURTON

ONE EVENING in the summer of 1948, in a rural community—the Green Sea High School District of Horry County, S. C.—a few people sat down to talk about what was happening to the boys and girls of the area. In the group were parents, high-school students, teachers, school trustees, a clergyman, the county superintendent of education, the guidance and the health consultant from the State department of education, and a representative of the Alliance for Guidance of Rural Youth (the present writer).

What brought these people together? First of all, the staff of the State department of education was concerned about the large proportion of school-age children who were not in school, and they knew that the problem was particularly acute in rural sections, where three-fourths of the people in the State live.

Next, about this time, they read in *The Child* (November 1947) about a program in Harlan County, Ky., which was developed with aid from the Alliance for Guidance of Rural Youth. This Kentucky program was helping to solve problems similar to those in South Carolina.

After some correspondence, the State department staff invited the Alliance to work with them in developing a rural youth-guidance project which would serve as a pilot program for the State.

Over the years the work of the Alliance in rural communities has been based upon a firm belief that each boy or girl is a valuable human being—a person possessing unique possibilities for individual development, happiness, and satisfactions. To help him plan his part in the world's work and make the best possible use of his life, the individual needs guidance in learning to understand himself, in recognizing his capabilities and shortcomings, and in developing the kind of personality through which he, as a citizen and a worker, can contribute richly to his environment.

Correcting defects is an important step toward helping children make the most of their lives.

Rural people the country over seldom have the services usually considered essential to a guidance program. Often a physician and a nurse cannot be found, even in an emergency. Psychiatrists, psychologists, counselors are practically unknown to the rural community. However, a rural community does include parents, teachers, and principals; and the community itself—when stirred to united action, using the resources available—can give better opportunity that will add quality to living for each boy and girl and for the community.

The next step was to select a rural community with the following characteristics: (1) Its chief source of income would be agriculture. (2) It would have the financial ability to provide adequate services for its young people. (3) It would include a high school and several elementary "feeder" schools. (4) It would have potential leadership that was interested in young people—this would assure personnel to carry through the program. (5) It would not be carrying on any major project to distract the people's interest. (6) Its problems concerning children and youth would be similar to those in other rural areas in the State. (7) Most important, its local people would be interested in doing a better job in developing healthy, happy, useful citizens.

The place selected for the pilot program was the Green Sea High School District, in Horry County. The county superintendent of education welcomed the project.

Green Sea—the land and the people

The Green Sea High School District is a strictly agricultural community. Tobacco is the chief cash crop. Scattered through an area of 56 square miles, and around the high school, are 17 feeder elementary schools of one, two, three, or four rooms. Each elementary school is the center of a very small farm community. Green Sea is not far from the North Carolina border, nor from the Atlantic Ocean.

Until the last two decades, when roads were paved and bridges improved, comnunication with this section of the State vas difficult. But, over the years, the armer, with help from his wife, his hildren and his mule, and of late his ractor, has cleared the land: and he as prospered through cultivating this ich, fertile soil. An excellent quality obacco leaf is grown.

Tobacco is an exacting crop that requires much hand labor and careful nurture. Children early take responsibility for helping with field work, for the family income is at stake. Boys and girls from 6 and 7 years of age up help with the various processes. The plant beds are seeded in December and January, and the fields are made ready in the early months of the year. Transplanting of seedlings begins in March or April. The seedlings are pulled from the seed beds in the morning, usually by an adult. When the children come from school—if they go at all during this season—they help to place the plants in the rows, to carry water, and to water the plants. (School hours are adjusted to the needs of the farmers for the help of their children. For example, a school may begin at 7 in the morning and continue without recess or a lunch period until noon, when the school day is over.)

During the growing period—late spring and summer—the rows need constant cultivation and close watch for insect attack or blight that might harm the leaf. Then comes preparing the tobacco barns, suckering the plants, and cropping the mature leaf. Stringing, curing, grading, and tying the leaf follow. The leaf is marketed in August and September. The family then begins to dig potatoes, to pick cotton and corn, to plant the winter garden, and to kill, cure, and process hogs. But from March to October everything is set aside for tobacco. The community eats, sleeps, thinks, lives tobacco.

A rural community has problems of democracy

Green Sea people, like many others, were not accustomed to coming together and giving time, thought, and effort to their community. The organization and administration of their school, health, and welfare services were left to a few interested people.

However, when the people first met to discuss the possibility of developing a youth-guidance program (this was in May 1948) and met again a few weeks later and decided to go ahead, they realized that if the program was to be successful it must belong to the whole community. This meant that it must be developed by persons representing each of the local elementary schools. Full democratic participation was wanted for this project.

It was early summer, and farmers were busy. Few people had telephones, and a written message would receive little attention. How could the people be induced to come to meetings to plan with and for their young people?

Citizen responsibility moves ahead

This is what was done to bring the people to the initial planning meetings: In each elementary-school area, on the morning of the day set for the meeting, consultants from the State department of education (there were usually at least two or three) who had come nearly 150 miles across the State for the meeting and a representative from the Alliance for Guidance of Rural Youth teamed up with a local person—a teacher, a public-health nurse, or another person known to the community. Each team spent the day visiting designated regions and talking with community leaders. These visits carried them into the school, into homes and fields. Often a conversation took place while a farmer halted his mule or tractor in the field, and after mention of the condition of the crop or the weather, talk drifted to the farmer's opinions regarding the young people of the Green Sea area. Could the community do any better for their boys and girls than it was then doing? Would he and his wife like to come to a meeting at the high school that night to talk with others about the young people and what was happening to them?

A community planning council develops

For studying problems affecting young people and carrying forward suggested action, it was essential to have an organized, responsible planning group. At the second meeting such a planning council was organized, with elected officers—a chairman, a vice chairman, a secretary, and a treasurer.

The planning council met monthly—discussed problems and needs of the young people and how they could be met. Some of the young people themselves were present to help out with ideas.

At these meetings problems listed on the blackboard over and over again were:

> **Too few children come to school regularly, and too many drop out early.**
> **No place to go and nothing to do, for the young people.**
> **Doctors are hard to get when we need them, because of distance.**
> **We don't have enough public-health nurses.**
> **We have no drug store.**
> **Our children are ill too much.**
> **We have too much hookworm.**
> **Schools and homes are not always sanitary.**
> **Our children marry too young and drift into sharecropping—they need guidance.**
> **Money is more important than education to some of our children. They need to learn better values.**
> **We need better telephone service and better roads.**

The people of the community could proceed only if they had concrete facts. They needed to know more about their young people, and so a committee was appointed to take charge of a survey of youth in the community. The committee prepared a questionnaire regarding boys and girls 6 to 18 years of age. It asked whether the young person was enrolled in school. If he was out of school, it asked his age at leaving, the last grade completed, and when he was last enrolled. If he was employed, it asked the kind of work he did. Someone in each elementary-school area was to be responsible for visiting each home.

The findings of the survey substantiated school records showing that many 13- and 14-year-old boys and girls were not in school. Of 238 pupils enrolled in grades eight through eleven during the 1947–48 school year, 80, or nearly one-third, failed to enroll in the next school year (1948–49). Many

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The Alliance for Guidance of Rural Youth is an organization interested in promoting guidance services for that large proportion of the Nation's children who live in rural sections of our country and who rarely have opportunity comparable to that available to urban youth for realizing their potentialities. For further information write the Alliance, 1201 Sixteenth Street NW., Washington 6, D. C.

children who reached the seventh grade failed to go on to the eighth grade. Also, many children, after attending high school for a year, left. The survey showed that many boys and girls of 12 and 13 years had left school with only a fourth-, fifth-, or sixth-grade education. The reason given by most of the young people was that they were helping with farm work at home. Again, some were out of school because of a physical or mental handicap, such as blindness, deafness, a crippling condition, poor eyesight, asthma, or epilepsy. Many had left school to marry when only 15 or 16 years old and now had children and homes of their own.

A springboard for action

The planning council decided to hold a 3-day youth-guidance institute in the spring of 1949, to give the community—teachers, parents, school trustees, youth, and all persons interested—the opportunity through free discussion to decide what to do about the problems that their studies revealed and that they had been listing on the blackboard for several months. Visiting consultants would be invited to help with plans.

The program committee included an adult and a young person from each of the elementary-school areas; and consultants were available among the health, guidance, and vocational-education supervisors from the State department of education and from the Alliance for Guidance of Rural Youth. Other committees were on registration, hospitality, records, arrangements, exhibits, music, recreation, publicity, and meals. The young people banded together in an organization known as the Youth Round Table.

Who came to the institute

Everyone in the community was urged to attend the institute, through invitations carried home by the school children, through publicity in newspapers of neighboring towns, and through special visits. Some 390 persons registered for the institute, and some additional ones attended the various meetings. About one-third gave their occupation on the registration blank as "farmers." Some left their work in the fields and came in work clothes. There were housewives, a few high-school students, lunchroom workers, a bookkeeper, a physician, an insurance agent, a university professor, a seamstress, a minister, and officials from local, county, and State and national agencies for education, health, welfare, employment, and agriculture.

Several general sessions of the institute were held, in which all participated, and each of eight small discussion groups met twice during the 3 days.

What constitutes a good community in which to grow and live, the topic of the first meeting, started people thinking about objectives. They decided that a community was a set of interests; that a community exists when it serves these interests, but if people must go outside the area to satisfy their wants, the community dies. A community, therefore, they felt, is a joining of hands to do things that cannot be done individually.

When a State nutritionist, shown here, made a study of the food eaten on a sample day by the children in two elementary schools, these high-school students helped to tabulate the data.

What is happening to our children was the theme of another general meeting. This discussed findings of the youth survey and other studies of school enrollment, retardation, and drop-outs. Ideas about these problems were carried into the small discussion groups, in which recommendations for their solution were proposed.

How the community can help to make its young people healthy was dramatized by a group of sixth graders with their teacher, along with public-health workers. They showed how the public-health nurse, the health officer of the county, the county sanitarian, and the State supervisor of schoolhouse planning could assist in the health program in the schools.

What is the occupational outlook for Green Sea youth was the question asked at the final general session. Discussion of this question brought out the fact that the farmers in the area are buying equipment, and as they get it they want more land. No longer are they content to farm a 25-acre tract, as in the past. Consequently, boys and girls now growing up, who want to stay in the community, will have less opportunity to stay and farm.

But there are things the young people can and should do, the meeting agreed. They can study and apply improved farm methods; they can explore the possibilities of new jobs that will utilize resources now not fully used; and they can also look for jobs that will meet community needs.

As for the community needs, only half of the possible corn production in the region is now achieved. Conditions are ideal for growing a high-quality sweet potato, and the market is enormous for that product; but the community is falling short in the quality and quantity of its production. The forests can produce twice what they are now producing. New farm equipment needs servicing; the farmers need such supplies as lime and spreaders. The community needs telephones, and it needs skilled artisans such as carpenters, paperhangers, electricians, and plumbers. Potential recreation resources—the woodlands, the streams, he ocean beaches—could draw vacationists; but visitors need a comfortable place to stay and good food.

What can be done about providing needed professional services? If the community is to be up to the average of the country in providing health services, the number of doctors, dentists, nurses, and hospital beds needs to be doubled. Many teachers must be added if schools are to be properly staffed and provide the educational programs that will fit young people and adults for work needed.

The groups set their goals

The small groups drew persons of similar interests: Primary teachers met together; likewise intermediate teachers, secondary teachers, health workers, lunchroom and nutrition-education workers, parents and school trustees, and out-of-school youth and veterans. High-school students met at the Youth Round Table.

The recommendations of the various groups were mimeographed and a copy was presented to each participant at the final session of the institute, so that everyone had the opportunity to review the recommendations as they were read, discuss them, and check whether he thought each was practical, and whether he was willing to put it into operation, and whether he needed help in putting it into operation. Nearly all the recommendations were unanimously adopted.

Never was the individual boy or girl lost sight of in the discussions by the institute. Each recommendation was concerned with giving each child and young person a better future. Groups recommended: (1) Methods for understanding the individual, (2) planning classroom activities to meet individual needs, (3) giving the individual the special attention that his needs required, (4) improving the health of the individual by keeping schoolrooms well-ventilated and well-lighted, (5) developing cumulative records, including date of birth of each child, results of his vision and hearing tests, and other information needed to give a picture of the child, (6) selecting one child in each class for special study, (7) giving young people opportunity to help plan the school program and, (8) teachers' study courses in child growth and development.

If guidance is to succeed

The people of Green Sea knew that first things must come first. They realized that a child with hookworm, which often results in anemia, or a child who had had malaria often, or a child who had not been immunized against smallpox, typhoid, or diphtheria, needed attention given to his health problems. The sanitation of his home and of his school often needed improvement. Many of the children needed to learn and practice good health habits.

More public health services were needed. Often, mothers with their children came to the home of the public-health nurse from 6 to 8 o'clock in the morning, hoping to have their children immunized or to get advice before the nurse left for her work. Again, they came from 5:30 to 8 in the evening after she returned from work.

The planning council authorized its health committee to make a survey for the purpose of determining the need for immunization services and to discover facts about sanitation. The committee was to prepare a questionnaire so as to obtain health information from every household in the area. It asked data for each member relating to age, school-enrollment status in the 1948–49 school year, and grade in which enrolled; also, data on whether the individual had had smallpox, typhoid, diphtheria, or whooping cough, or whether he had been immunized against them. It asked whether the person had been immunized against tetanus and whether he had been tested for hookworm and had received treatment. Further, information was to be obtained from each household regarding the source of water supply: (1) whether the well was deep or shallow; (2) type of pump—electric, hand force, pitcher, or bucket and chain, or (3) whether the water was from a spring. The questionnaire also asked about the family's toilet: whether it had a septic tank or other flush system, or was a pit privy or an open privy; or whether the family had no toilet. Another question was on the kind of lighting used—electric, oil lamp, or other. In each elementary-school area a member of the health committee was given responsibility for seeing that as many households in her area as possible were visited.

A total of 505 households were visited. These had 2,400 members, 1,130 of whom were 18 years of age or over, and 1,270 under 18. A relatively high incidence of smallpox had existed; also of typhoid (5 percent of the older group and 1.7 percent of the younger), and of diphtheria (3.7 percent of the older group and 5.6 percent of the younger). A study of the schedules showed that some children enrolled in school had not been immunized even against smallpox, though vaccination is required by State regulation. Few of the preschool children had been immunized against any disease.

Hookworm is prevalent in the area. The county health officer estimates that more than half of the people in the Green Sea district have hookworm infestation; and that in some localities, 75 percent are infested. Among the 2,400 individuals included in the study, 468 reported having been tested for hookworm, and half of these reported having had treatment—indicating that hookworm had been present.

Some health hazards unnecessary

A State sanitarian examined the findings of this study relating to water supply and toilets and summarized them as follows: In the 505 households, about 28 percent of the pumps were judged safe and 63 percent potentially unsafe. Two hundred and fifty-eight households had pitcher pumps; 59 had bucket-and-chain pumps; 47 had hand force pumps. Information for other households was not reported. The health department regards the pitcher type and the bucket-and-chain type as potentially dangerous, because the water must pass over an exposed surface and because the wells are likely to contain surface water.

Only 66 families had toilets with septic tanks or other flush facilities; 133 reported that they had no toilet. Others reported having the pit-privy type, which the health department also considers potentially unsafe.

Since 70 percent of the households reported having electricity, it would be possible for that proportion of them to have a safe water supply and a septic tank. Therefore the present health

What points must we check when we inspect the sanitation of a lunchroom? A member of the county health-department staff works with a committee of students in a community project.

hazards from water supply and toilets are unnecessary.

Organized effort succeeds

The youth-guidance institute provided the pattern for democratic action and the stimulus to carry forward the program of guidance in Green Sea. Specific lines of attack spontaneously developed to put into action the recommendations of the "big institute," as it was called locally. All activities relating to the program have sprung from local recognition of problems, and efforts to solve these problems have been based on democratic participation.

The program has been executed by three groups, the work of one often closely interwoven with the others: (1) The community planning council, which has over-all supervision of the program, gives impetus to improving conditions and providing services that make effective guidance possible and encourages development of an organized guidance program in the schools; (2) principals and teachers, who take part in the planning council and have specific responsibility for developing the guidance program in the school; and (3) the young people, who through their Youth Round Table participate as a young citizens' group in the planning council and also carry responsibilities that are usually undertaken by a student council in the high school.

At each of the monthly meetings the council reviews the progress of the community's program, decides upon next steps, and delegates responsibility for new ventures. The council has used State public and private resources fully. For example, it cooperated with the State guidance consultant in making a study of school enrollment, retardation, and drop-outs in the Green Sea High School District. It sponsored a health institute in the spring of 1950; and, in preparation for that, the health-education consultant from the State department of education helped to arrange for a survey of the schools by a State sanitarian and a sample 1-day diet survey by a State department of health nutritionist. The council has also organized and successfully carried through a bond issue to finance building of an agriculture room, a workshop, and a lunchroom for the high school. It has helped the young people to obtain land and erect a community recreation center; and it sponsors a Boy Scout troop and has helped them find land and make a swimming hole. The council inspires, encourages, and carries through action.

School and community move together.

The teacher is recognized as a key person, along with the parents, in assuming responsibility for individual guidance of the children. An important recommendation of the teachers at the institute was for in-service education to help them understand children. To carry out this recommendation the planning council has helped to arrange several conferences with consultants from the State department of education. In addition, the teachers meet regularly to discuss case studies of individual children and to work out solutions together for problems they find.

Aiding young people in self-development

In the high school, interest-inventory tests were given the children in the tenth and twelfth grades, and homeroom periods were used to counsel individuals and groups about the findings of the tests. Also, for each high-school student the results of these tests have been put into the cumulative record. A special effort has been made to study each child in the eighth grade, as that is the grade in which the largest number of pupils leave school.

In the Green Sea High School, the boys and girls held a "career day", with discussion focused on community needs, as revealed by the sanitation and diet surveys. A large proportion of the boys take the agricultural course, and this requires each student to have a home program, including three types of projects: (1) A profitable money-making project, which involves management decisions; (2) home improvements related to such things as wells, privies, bathrooms, and septic tanks; (3) supplementary jobs having to do with feeding livestock, marketing, and so forth.

The State health department and the State education department have cooperated in offering agricultural teachers summer courses in building sanitary privies, septic tanks, and safe wells and water supply. The Green Sea agricultural teacher took this course and will help the boys in the agricultural course with improving home sanitary facilities.

Because the diet survey showed that the children lacked milk and vegetables the young people will be encouraged to keep a cow and to grow vegetables for family use.

The Youth Round Table

The high-school students liked the start the Youth Round Table had made

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LATIN-AMERICAN LAWS SHOW MORE MODERN ATTITUDES TOWARD ADOPTION

ANNA KALET SMITH

WHEN THE LANDS of the New World, first called the Indies, were discovered and became possessions of the crown of Castile, the history of adoption legislation in Latin America began. That history has three periods. During colonial times, which ended for most of the countries before the middle of the nineteenth century, adoption practice was guided in the Spanish colonies by Spanish law, modeled after the Roman tradition. Adjustments were occasionally made to fit local needs.

The Portuguese territory, which later became Brazil, had no adoption law; the very infrequent adoptions there were decided by Roman law.

Spanish law on adoptions contained various restrictions. It was apparently intended mainly for well-situated persons who lacked an heir to continue an aristocratic name or to keep an estate in the family, or who, perhaps, wanted a child in their home. In any event, the interest of the family rather than of the adoptive child was the primary principle.

In the course of the nineteenth century, when the Spanish empire in America fell apart, and self-governing countries arose in its place, these countries began replacing the original colonial law by independent legislation. This opened the second stage of legal regulation of adoption. Along with the political revolutions came a change in social ideas. But the builders of the new countries saw little need for adoption legislation in the disturbed society of those years; consequently, many of the countries ignored the subject in drafting their new laws. The social values of adoption were still largely unrecognized.

The few Latin-American countries that enacted adoption laws in that period accepted the principles of France's basic law, the Code Napoléon. That Code set a high minimum age for the adoptive parent, limited the adoption of children to childless persons, and set up other restrictions that often prevented adoption.

In time, further changes in the attitude toward adoption began to develop. The consequences of World War I were a significant spur to that development. Latin-American countries, aware of the plight in Europe of countless children orphaned by the war, became concerned about their own homeless and destitute children. A step toward bringing about a better life for these children was the realization by these countries that they needed liberal adoption laws. That realization marks the beginning of the third period in the history of adoption legislation in Latin America.

An outstanding event of those years was the Fourth Pan American Child Congress, held in Santiago, Chile, 1924. A United States delegation took part, including Katharine F. Lenroot, the present Chief of the Children's Bureau. That Congress was the first interna-

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tional gathering in Latin America to stress the need for good adoption laws. Several countries took action as a result of the interest shown, and adoption continued to be discussed on subsequent occasions. One occasion was the Ninth Pan American Child Congress, held in 1948 in Caracas, Venezuela, with Miss Lenroot heading the delegates from the United States.

Reactions to the discussions during the congresses and in the intervals between them stimulated the liberalization of existing laws or brought about enactment of new ones that reflected social trends. So today, 25 years after the memorable Fourth Pan American Child Congress, 15 Latin-American countries have adoption laws and the other 5 are considering such measures.

These Latin-American laws differ, substantially. The older ones limit the right of adoption to childless persons who are beyond the age when they are likely to have children of their own. The newer ones, however, recognizing in varying degrees the importance of adoption, aim to facilitate the procedure and also to safeguard the child. Uruguay's legislation is noteworthy for its solicitude for the child to be adopted and for the predominant role in the adoption procedure it assigns to child-welfare agencies. Nearly all the laws are concerned with the adoption of adults as well as of children, but here we confine ourselves to the sections that affect children.

The ages of adoptive parent and child

These Latin-American laws invariably specify, among other conditions for adoption, a minimum age at which a person may adopt a child. In the earlier laws this was 50 years, and this age is still retained in Bolivia, Brazil, and Peru. This high age limit was prescribed in order to safeguard the legitimately constituted family against intrusions, because at this age the probability of marriage and parenthood is slight. In the course of time, however, the disadvantage of this requirement—that it often acted as an obstacle to adoption—became obvious, and lower age limits were allowed.

In the 12 other countries that have adoption laws, the minimum age for an adoptive parent varies at present from 21 years in Colombia and Panama to 45 years in Cuba. Also, in some countries a married couple may adopt a child at an earlier age than a single person may, usually on the condition that they have no children and have been married from 5 to 10 years. The exact period varies in different countries.

All the laws except Guatemala's require a certain difference between the age of the adoptive parent and of the child. This difference varies from 15 to 20 years; in most countries it is 18 years.

In Bolivia the law prohibits the adoption of children younger than 14 years of age. However, the specification of a minimum age for the child is not found in the law of any other country.

If adoptive parents have children of their own

Most Latin-American laws are careful to limit the right to adopt a child to persons without children of their own. The purpose of this restriction is to prevent possible conflicts in the future between the claims of the children born in the family and those of an adopted child. One country, Colombia, whose law of 1873 is still in effect, goes so far with this aim as to require the termination of an adoption after the birth of a child in wedlock to the adoptive parents. In the other countries, the birth of a child after the parents have adopted one does not affect the status of their adopted son or daughter. Specific statements to that effect are made in the laws for the purpose of avoiding misunderstandings. The more advanced laws, notably those of Uruguay and Argentina, allow adoption regardless of whether the prospective parents have children of their own. In Venezuela the Council of the Child, an official child-welfare agency of national scope, advises the court on the cases in which married couples with children of their own ask that an exception be made to permit them to adopt a child.

Who must agree to an adoption

Almost all the adoption laws require that the child's natural parent consent to the adoption; some, however, allow the judge to disregard the parent's opposition to adoption. When a married couple adopts a child, the agreement of both prospective parents is necessary. If the child is in the care of a public welfare agency, the agency must consent to the adoption. In several countries a minor child's consent to his own adoption is required if he is older than an age specified, varying from 12 to 18 years, according to the country. In Cuba a child must be "consulted" if he is at least 7 years of age, and in Argentina if he is 10. In neither of these two countries does the law state whether the child's wish must be followed; the assumption seems justified that the judge considers it in making his decision.

Protection of the adoptive child has been one of the objectives of the adoption laws, but with great variations.

For children in Latin-American countries, as elsewhere in the world, sound laws on adoption and other legislation concerned with children provide a foundation for child-welfare services.

The earlier laws, and some later ones, aim chiefly at protecting the child's property. To this end, a child's adoption by his guardian is permitted only after the guardian's accounting of the child's property has been found to be in order. As an additional precaution, in some countries, Peru for one, a ward who has property cannot be adopted before he is of age; in Colombia and Panama he must be 18 years old. In Colombia and Cuba a parent is deprived of any right to inherit from the adopted child, in order to prevent adoptions being made merely for financial gain. An adoptive parent may inherit under the child's will in Argentina, Costa Rica, and Peru. Several laws remain silent on this subject.

Other trends in the protection of the child about to be adopted are concerned with his general well-being and illustrate the recent development of child-welfare principles. Their practical applications, however, differ considerably. The laws of some countries limit themselves to general directions to the judge hearing adoption cases, such as "to take such measures as he may consider necessary for the welfare of the child." Without going into detail, other laws require the judge to ascertain whether the adoption promises to be of benefit to the child. Still others call for character testimony concerning the adoptive parent.

In contrast to these general provisions, the laws of Ecuador, Uruguay, and Venezuela require investigation of all the circumstances surrounding the proposed adoption. Another modern practice in four countries is the rule requiring the child to have been under the adoptive parent's "protection and care" for a certain period before the filing of the adoption petition. In Ecuador this period is 6 months; in Argentina 2 years; and in Uruguay it is 2 years according to the Children's Code of 1934, and 3 years under a law of 1945 concerning special categories of children. A step in this direction has also been taken in Venezuela, where the law of 1949 requires a period of trial residence in the adoptive home in the cases of neglected children who are wards of the state. The length of residence is decided for each child separately.

Procedure specified

Approval by a court is necessary in nearly all the countries. The petition for adoption, with a statement of the consent of the parties concerned and other information required, must be presented to the court. The adoptive parent and the natural parent or the guardian, and, in some countries, the child, if he is older than a specified age, must be present at the hearing. In some cases representatives of public child-welfare agencies must appear also. The court ascertains as far as possible whether the conditions prescribed by law for adoption have been met.

In a few countries, Brazil, for example, no court approval is necessary, but a deed must be drawn up by a notary. In Colombia, if there is no district court in the locality, approval by a specified public agency is sufficient. In Venezuela, local courts grant petitions for adoption. But in cases of neglected children who are wards of the state, the Venezuelan Council of the Child is the authorizing agency. Also, when a married couple who already have one or more children, and are therefore prohibited from adopting a child, ask for an exemption from the law, the Council is required to investigate the circumstances and make a recommendation to the court. Under Ecuador's law, only a juvenile court may approve an adoption. Uruguay has two different procedures. In cases under the Children's Code of 1934, a deed must be drawn up by a notary and submitted for approval to the Council of the Child; in cases regulated by the law of 1945, which as previously mentioned applies to children in special categories, the petition must be presented to the juvenile court.

The importance of having official records of adoptions is generally recognized in Latin America, so that in almost all the countries each adoption must be recorded on the register of vital statistics. In some countries, failure to do this within the period specified is punishable by a fine. In Uruguay, an adoption under the Children's Code must be recorded in a special register in the local bureau of vital statistics.

Legal effects of adoption

Adoption in Latin America creates a legal relationship that, except for certain children in one country, is limited to the adoptive parent and child; it creates no relationship between either of them and the natural family of the other. The exception is that in Uruguay, a child adopted under the law for special categories of children becomes the brother or sister of the children born to the adoptive parents.

In all the countries adoption is followed by a change in the child's surname. This is done in some countries by substituting the adoptive parent's surname for the child's; in others, by combining the two surnames. These changes are optional in some countries, compulsory in others.

As with many other countries, the laws in Latin America provide that parental rights and duties shall be transferred from the child's natural parent or guardian to the adoptive parent, who must assume the care and support of the child.

But in almost all the countries, if the adoptive parent becomes unable to provide support, the adopted child is entitled to receive it from his natural parent; in turn, a child must help his natural parent when the latter is in need. A significant exception is the Uruguayan law for special categories of children, under which the child is decreed to be the child of his adoptive parents, and under which all legal relationship between the child and his natural parent ends.

As another consequence of adoption, the child in Latin America becomes entitled to inherit from an adoptive parent who fails to leave a will. The conditions of such inheritance vary in the different countries. In Uruguay, under the law of 1945, and in the Dominican Republic the adopted child is entitled to inherit from the parent with or without a will, just as though he had been born to the parent. This is also true of Uruguay under the Children's Code of 1934, and of Guatemala, but only in the absence of certain heirs specified in the law. In some countries the adopted child receives a smaller share than that due under the law to a child born to the parent. In others, the adopted child can inherit only by

(*Continued on page 69*)

To Convert Findings Into Action

Organization of a citizens' committee, which will convert into action the findings of the Midcentury White House Conference on Children and Youth, has been voted unanimously by the national committee for the conference. The vote, taken at a recent meeting of the national committee, held in Washington, came as the result of the recommendations of a subcommittee appointed by the chairman of the National Committee, Oscar R. Ewing.

National Committee members agreed that a specific organization must be established to carry through the work of the conference, if the maximum benefits to children are to be realized. The group adopted a seven-point plan:

1. The new organization should be a voluntary, broadly representative citizens' group, which includes the present important interests and groups in the Midcentury White House Conference.

2. The function of the group should be to coordinate, channel, publicize, and implement for action the findings brought out of the Conference.

3. An interim committee is to be appointed immediately. Its membership will include members of the National Committee and representatives of the conference advisory councils.

4. The interim committee is to lay plans for the citizens' committee, outline a program, set criteria for membership, and recruit the initial funds necessary to get the program under way. It was estimated that $25,000 would be necessary to carry on the work for the first 6 months.

5. The National Committee authorized the assignment of a staff member to begin work on the action in advance of the conference meetings.

6. The name of the new group is to reflect the concept of citizens' action in relation to children and youth. The suggested name was "National Citizens' Committee for Children and Youth."

7. It was estimated that the life span of the citizens' committee would be from 2½ to 3 years.

The need for a special organization to implement the findings of the conference has long been expressed by conference participants throughout the Nation.

In May of this year the advisory council on national organizations recommended that full consideration be given to a conference follow-up program.

At a meeting in Chicago last June the advisory council on State and local action strongly urged that such an organization be created. Council members pointed out that a staff with full knowledge of the work of the conference should be maintained to stimulate the development of State and local action programs and to implement the distribution of conference materials to the public.

In August, the youth council also took similar action.

In summing up the plan adopted by the National Committee, Melvin A. Glasser, Executive Director of the Midcentury Conference, said, "The real test of the value of the conference will come after the December meetings, when citizens and professional workers begin to put into practice the findings and recommendations of the 5,000 delegates. This is the first time a White House Conference has attempted to bring together such a comprehensive body of information on the growth and development of children. It is the first White House Conference in which there has been Nation-wide participation, in advance of the conference itself, by parents, teachers, doctors and all others directly concerned with the well-being of our children. It is the first time such great opportunities have existed to improve the future of all children and young people in the United States."

Better Start in Life

(Continued from page 59)

Federal grants; to qualify for child-welfare funds each State must assume some of the cost of services in rural areas.

So long as States meet the requirements of the Social Security Act, they are free to use Federal funds in the way they think best. This is one of the great strengths of these grant-in-aid programs: they preserve and respect State and local initiative.

As we go to press, State child-health and child-welfare officials are meeting with representatives of the Children's Bureau to talk over their plans for using the increased aid which the Federal Government is offering under the new amendments to the Social Security Act.

Some will be able to hold more clinics for pregnant mothers and for well babies. Some will be able to open clinic and hospital doors to more children who are suffering from crooked bones or injured muscles, from skin diseases or injuries. Other States will be able to do something for children they've never helped before: children who are hard of hearing, who have rheumatic fever, epilepsy, or cerebral palsy. All the States will be improving their child-welfare services for children with serious emotional and social problems; children who have lost one or both parents, who are neglected, homeless, or in danger of becoming delinquent.

Because one of the serious problems facing children is the shortage of trained workers, all the States will be putting some of their "new" money to work in increasing the number of workers who are skilled in meeting the very special needs of human beings in their formative years.

No one can predict just how many children will be helped with the increased Federal funds for services or for public assistance, nor how many children each year will lose their fathers or mothers and so become eligible for financial help through insurance.

But one thing is certain: the new social-security law will make life for many children a little less hazardous, a little less burdensome, and a little happier, thanks to a program of social security that allows everyone to share in the misfortunes of each of us.

Latin-American Laws

(*Continued from page 67*)

will, unless the adoption papers designated him as an heir.

Invalidation of adoption

Invalidation of adoption is permitted by all the Latin-American laws, with two exceptions. These are the Bolivian adoption law of 1831, the oldest on this subject now in effect in Latin America, which makes no mention of invalidation, and the Uruguayan law of 1945 which prohibits invalidation.

The adoption laws distinguish between invalidation at the request of the adoptive parent on grounds placing blame on the child, and invalidation at the complaint of the child or his guardian against the adoptive parent. Invalidation at the request of the adoptive parent is permitted in some countries when the child is guilty of "ingratitude" or "indignity." These terms, as interpreted in some laws, apply to acts for which a child may be disinherited, among them (1) being convicted of a crime against the adoptive parent or members of his family punishable by more than 1 year of imprisonment; (2) court action by the boy or girl accusing the adoptive parent of a serious crime; and (3) refusal to contribute to the support of the adoptive parent when he is in need.

Other countries permit invalidation not only on these grounds but also on the request of the child or his representative when the adoptive parent commits a crime against the child, or mistreats him, or fails to support him, or shows moral depravity.

Some laws permit invalidation on "serious" or "justifiable" grounds without defining these grounds and leave the matter to the discretion of the judge, who is duty bound to decide in the best interests of the child. In some countries adoption may be invalidated on the joint request of the adoptive parent and child in addition to all or some of the previously mentioned grounds.

Failure to comply with any of the provisions of the adoption law is in some countries ground for annulment, as distinguished from invalidation.

Invalidation is decreed by the agency that approved the adoption, which is, as a rule, the local court.

Rural Children

(*Continued from page 64*)

and decided to continue to work with the community planning council as a "young citizen's league" and at the same time to serve as a student council.

From the beginning of the program, the young people have said that the greatest problem for high-school boys and girls was that they had "no place to go and nothing to do." This has been the root of many problems, such as early school leaving, delinquency, and early marriages.

The trouble was this: Most of the young people lived on scattered farms. They came to school on the bus, went to classes, returned home on the bus, did their chores, and went to bed. This routine was broken now and then by fishing, hunting, and playing ball. But the young people said that they had little opportunity to get acquainted with other boys and girls at school and enjoy pleasurable association with them.

A first achievement of the youth group—and a very important one for them—was working out a schedule with the school staff so that each student had a daily period for recreation and other activities of his choice. The school administration helped, and the young people raised money themselves to buy ping-pong sets, softballs, footballs, checkers, and such other equipment for games and hobbies as they chose.

The young people are grateful for the changes that have come to their school and community. The recreation and activities period, opportunity to take the interest-inventory test, the career day, the use of the home-room period for guidance purposes, all have helped to give them direction in planning for a full use of their lives in accordance with their interests and capabilities. They are pleased with their own part in the changes that have been made; they seem happier; and they are "getting along better"—so they said—now that parents and friends of children are taking more interest in the welfare of the school and the young people.

But the parents, the teachers, and the young people themselves are much concerned about the number of boys and girls who are not in school because they must work on the farm or because the children and their parents do not recognize the importance of schooling. They recognize that irregular attendance leads boys and girls to fall behind in their school work and leads them to discouragement and dropping out of school. But they are confident that as going to school becomes more attractive and the people become more interested in the schools the community will solve the problem.

Green Sea's course is now charted for guiding its children and young people toward realizing their best possibilities. The people of Green Sea are determinedly steering toward their goal.

Reprints in about 6 weeks

• IN THE NEWS

New Role for Dr. Baumgartner

Katharine F. Lenroot, Chief of the Children's Bureau, Federal Security Agency, has announced that she has regretfully accepted the resignation of Dr. Leona Baumgartner who, since June 1949, has been Associate Chief of the Bureau.

Dr. Baumgartner, who for personal reasons finds it necessary to relinquish her full-time post with the Children's Bureau, will continue to serve it as an unsalaried special consultant on matters relating to the Bureau's programs of research and children's services. She returns to the position of Assistant Commissioner of Health, New York City, which she held before coming to Washington.

Commenting on Dr. Baumgartner's resignation as Associate Chief and her appointment as consultant, Miss Lenroot said:

"An experienced administrator of children's services in the great metropolitan area of New York and a close observer of these services in many small communities and many States, Dr. Baumgartner brought to the Children's Bureau a rich understanding and rare judgment. During her 15 months with us, she gave us devoted service in the total program of the Bureau. She knows first hand the problems that parents of children handicapped by polio, epilepsy, premature birth, and emotional difficulties face, and she knows what communities can do to get help to these children. A former research worker, Dr. Baumgartner gave valuable help in relation to the Bureau's research program.

"We are fortunate, indeed, that although we must forego the close association we have had with Dr. Baumgartner as Associate Chief, she has agreed to continue to work with us in a consultative capacity."

In her letter of resignation, Dr. Baumgartner said:

"I return to my post as Assistant Commissioner of Health of the City of New York with an added sense of pride in and understanding of the Children's Bureau's great contributions to the health and welfare of the Nation's 48 million children. . . . I am also happy to continue to serve the Bureau as special advisor to the Office of the Chief."

Dr. Baumgartner, a native of Illinois, worked with children and youth in Kansas, Montana, Connecticut, and New York, prior to coming to Washington. She holds a master's degree in bacteriology, and a Ph. D. in public health, in addition to her medical degree and graduate pediatric training. She is the author of many scientific articles and is a recognized authority in the children's field.

Japan's School Children Welcome Aid from U. N.

Japanese school children, waving United Nations flags, welcomed the recent arrival of a shipload of cotton, the first to be sent to Japan by the United Nations International Children's Emergency Fund (UNICEF). The cotton will be made into children's clothing and the finished articles distributed free to some 300,000 needy children.

For Maternal and Child Health in India

The World Health Organization and the Indian health services have cooperated in setting up a field center for maternal and child health in a rural area of Delhi Province in India. This project is being enlarged to form an over-all teaching and training project for medical students, nurses, and social workers, with courses in Delhi hospitals and colleges also. Additional centers in Afghanistan and Burma and other parts of Southeast Asia will help in the improvement of the health of mothers and children, and particularly in lowering the infant death rate.

For Children in Maryland With Epilepsy

Significant new medical advances in controlling epilepsy have made possible the first comprehensive, State-wide program to help epileptic children. This program will be carried out in Maryland, with the help of a special grant made by the Children's Bureau to the Maryland State Department of Health. It will be a demonstration program to help children in the counties of Maryland who have epilepsy.

The Johns Hopkins University School of Medicine and the University of Maryland School of Medicine will cooperate in carrying out the program.

The two medical schools will furnish specialists to help in the operation of two diagnostic clinics in Baltimore, both equipped with electroencephalographs, to which epileptic children throughout the State will be referred for diagnosis. All the county health departments expect to take an active part in the program by locating the children and referring them to the central clinics, by supplying the various drugs, and by working closely with local physicians in carrying out the treatment recommended in each case.

The program will be under the direction of Dr. Edward Davens, Chief of the Bureau of Maternal and Child Health in the Maryland State Department of Health.

Reprints Available

An Administrator, an Obstetrician, and a Maternity Supervisor Evaluate the Rooming-In Plan. By Hayward R. Hamrick, M. D., Thaddeus L. Montgomery, M. D., and E. Pauline Shenk, R. N. Reprinted from *The Modern Hospital*, August 1949.

Experiment in the Supervision of Cottage Parents. By David Hallowitz. Reprinted from *The Jewish Social Service Quarterly*, December 1948.

Guardianship of Children. By Alice Scott Hyatt. Reprinted from *Social Security Bulletin*, January–February 1950.

Hospital Fatality Rates for Premature Infants. By Katherine Bain, M. D., John P. Hubbard, M. D., and Maryland Y. Pennell, M. Sc. Hyg. Reprinted from *Pediatrics*, October 1949.

The Quality of Medical Care in a National Health Program; a statement by the subcommittee on medical care. Reprinted from *American Journal of Public Health*, July 1949.

Working Together for Children; the court and the children's agency. Reprinted from *Child Welfare*, July and November 1949.

Cerebral-palsied Children Graduate

A school for children with cerebral palsy at Charlanne, Ala., held its first high-school graduation last spring. The school was recently accredited by the State board of education, and many improvements have been made in the program and services of this resident institution. Two of the three high-school graduates have been under the care of the Alabama crippled children's program for years.

To Help Save Texas Prematures

A 50-page brochure entitled "Premature Infant Deaths Cast Shadows Over Texas" has been published by the Texas State Department of Health to publicize its State-wide program of care for premature infants. It offers guides and recommendations for managing services for premature infants.

Diabetic Children Go Camping

For the first time in the Southwest, a camp was held in the summer of 1950 for diabetic children. Held on a 400-acre site near Gainesville, Tex., it is called Camp Sweeney in honor of Dr. J. Shirley Sweeney, founder of the Sweeney Diabetic Foundation. The camping time was divided into six weekly periods, beginning in mid-June. No child between the ages of 6 and 15 with diabetes was turned away. The costs of the camp were defrayed through the efforts of Dr. Sweeney and the people of Gainesville. Emphasis was placed on helping the children lead a normal life and teaching them self-care. The staff included physicians, nurses, and dietitians.

More UNICEF Funds Allocated

The Executive Board of the United Nations International Children's Emergency Fund (UNICEF) has allocated $1,287,000 for relief of Palestine refugees and for children's aid programs in Israel, Finland, and Afghanistan. It also approved the allocation of $1,125,000 for children's programs in Latin American countries.

Psychological Service Centers Opened in India

Psychological service centers are being opened in five important cities in the United Provinces of India, to provide educational guidance to children between the ages of 5 and 13 years and vocational guidance to youths up to 20 years. A bureau of psychology is already functioning at Allahabad.

FOR YOUR BOOKSHELF

FETAL AND NEONATAL DEATH: a survey of the incidence, etiology, and anatomic manifestations of the conditions producing death of the fetus in utero and the infant in the early days of life, by Edith L. Potter, M. D., Ph. D., and Fred L. Adair, M. D. University of Chicago Press, Chicago. Revised edition, 1949. 173 pp. $3.75.

This excellent small book discusses the major causes of fetal and neonatal death under the headings of malformations, anoxia, birth trauma, prematurity, toxemia, and infections. Since the first edition appeared, 9 years ago, at least two medical advances of general interest have occurred in this field, namely, recognition of the effect on the fetus of the Rh factor and of German measles.

The book summarizes the broad experience and careful investigations of the authors and lays the foundation upon which further knowledge concerning stillbirth and neonatal mortality can be built.

Alice D. Chenoweth, M. D.

COMMUNITY HEALTH AND WELFARE SERVICES: 49 urban areas 1948. Community Chests and Councils of America, Inc., 155 East Forty-fourth Street, New York 17, N. Y. April 1950. 24 pp.

This annual report contains comprehensive statistical data on the volume of community health and welfare services in 49 urban communities during 1948. Included are such types of services as economic-assistance and social-adjustment services, health services, recreation, and informal education and group-work services. In addition to showing changes from 1947 to 1948, trends are presented for the period 1940 to 1948.

The report is especially useful because it presents figures on the services of both public and voluntary agencies. However, since all the cities covered in the report have over 100,000 population, the data should not be considered as representative of the country as a whole.

People working in the children's field will be interested in looking at the portions of the report on aid to dependent children, day-care centers, protective and foster care, and maternity-home care.

Jack Wiener

ESSENTIALS IN GOOD ADOPTION PRACTICES; a pamphlet for Child Welfare Workers. Child Placing and Adoption Committee of the State Charities Aid Association, 105 East Twenty-second Street, New York 10, N. Y., 1950. 78 pp. $1.

This excellent pamphlet was prepared by the committee on expansion of adoption services, which is a subcommittee of the Child Placing and Adoption Committee, of the New York State Charities Aid Association. It was written to give help to social workers placing children for adoption, in agencies not primarily geared to such work. The material recognizes adoption as an integral but specialized part of casework practice in the child-welfare field.

Part I takes up the principles that are basic in all good adoption planning, whether it concerns an infant, a young child, or an adolescent, and regardless of the child's creed or color. These principles are considered in relation to the natural parents, to the child, and to the adoptive family. Part II summarizes case illustrations that emphasize the principles discussed in Part I.

The pamphlet is a real addition to the limited material available regarding adoption procedures and practices.

I. Evelyn Smith

JUVENILE DELINQUENCY IN MODERN SOCIETY, by Martin H. Neumeyer. D. Van Nostrand Co., Inc. New York, 1949. 335 pp. $5.

The major portion of this volume is focused upon the conditioning factors of juvenile delinquency. These factors are grouped as follows: Personality factors, which include biological and psychological factors as well as character and behavior traits; home and family conditions; companions outside the home; influence of community institutions such as schools, churches, recreation agencies, and all forms of commercial recreation; population and cultural factors; economic and physical environmental factors; and law observance and enforcement factors. Results of studies and research in these areas are presented and discussed. The author is careful to point out that these factors and conditions are not necessarily causes, but are elements that may be related to delinquent behavior. He reminds us that there is no single cause of juvenile delinquency.

In taking this position, he does not imply that the problem is so complex that a main conditioning factor or problem cannot be discovered in the individual case or that all factors affect conduct with equal intensity. He says that "to reach a thorough understanding of deviant behavior, a complete history and an analysis of each individual case are essential, together with a full understanding of all environmental conditions under which the behavior takes place."

Although the author's emphasis is upon conditioning factors, he does discuss the subject of delinquency control. He includes under this heading apprehension, detention, juvenile courts and probation service, institutional care community services and organization, and methods of research. Some limitations in our present programs are pointed out and the need for coordination and integration of agencies and methods is expressed, but there is no sharp or critical analysis of the present programs or agencies concerned with or responsible for the control and treatment of delinquency.

William H. Sheridan

FOOD FOR LITTLE PEOPLE. By Hazel Kepler and Elizabeth Hessler. Funk & Wagnalls Co., New York, 1950. 276 pp. $3.75.

In highly readable style, the authors of this book present the accepted principles of sound nutrition and good food practices for children of preschool age. Humorous incidents and the recounting of childhood reactions to food in typical family situations are selected to help parents understand some of the underlying motivations of childhood behavior.

The title of one chapter, "Tricks in All Trades," might well serve as a subtitle for each chapter, for the entire book is filled with ideas on making food more interesting and on new and unusual ways of adding variety to well-known, easily followed recipes.

Supplementing the chapters on food during illness and convalescence and on sickroom diets is a chapter on "Entertainment of the Convalescent," which suggests many novel ideas for keeping the young convalescent happy and contented.

Helen R. Stacey

Illustrations:

Cover, Archie L. Hardy for Children's Bureau.

P. 58, General Services Administration (formerly Federal Works Agency).

Pp. 60 and 62, E. S. Powell for South Carolina State Board of Health.

P. 64, King Studio, Loris, S. C.

P. 65, Office of Inter-American Affairs.

P. 66, Encyclopaedia Britannica Films, Inc.

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• CALENDAR

(Begins Nov. 1)

Nov. 2–6—National Conference of Catholic Charities. Annual meeting. Washington, D. C.

Nov. 5–11—American Education Week. Thirtieth annual observance. Sponsored jointly by the National Education Association, the American Legion, the Office of Education, Federal Security Agency, the National Congress of Parents and Teachers. Information from the National Education Association, 1201 Sixteenth Street NW., Washington 6, D. C.

Nov. 7–10—School Food Service Association. Kansas City, Mo.

Nov. 9–11—American Speech and Hearing Association. Annual convention. Columbus, Ohio.

Nov. 12–18—Book Week. Thirty-second annual celebration. Information from Children's Book Council, 50 West Fifty-third Street, New York 19, N. Y.

Nov. 15–17—National Association of Intergroup Relations Officials. Fourth National Conference on Intergroup Relations, New York, N. Y.

Nov. 16–17—Family Service Association of America. Biennial meeting. New York, N. Y.

Nov. 16–17—National Committee for Mental Hygiene. Annual conference of the National Association for Mental Health. New York, N. Y.

Nov. 16–18—National Council of Negro Women. Fifteenth annual convention. Washington, D. C.

Nov. 16–18—Family Service Association of America. Biennial meeting. New York, N. Y.

Nov. 20–21—National Social Welfare Assembly. Annual meeting. New York, N. Y.

Nov. 30–Dec. 2—American Public Welfare Association. Annual Round Table Conference, featuring the organization's twentieth anniversary. Chicago, Ill.

Dec. 3–7—Midcentury White House Conference on Children and Youth. Washington, D. C.

Dec. 26–28—American Association for the Advancement of Science. Cleveland, Ohio.

Dec. 27–29—American Statistical Association. Annual meeting. Chicago, Ill.

Dec. 27–30—American Economic Association. Annual meeting. Chicago, Ill.

Dec. 28–30—American Political Science Association. Annual meeting. Washington, D. C.

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DECEMBER 1950

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COMMUNITY PLANNING AND CITIZEN PARTICIPATION IN BEHALF OF CHILDREN AND YOUTH

KATHARINE F. LENROOT
Chief, Children's Bureau

COMMUNITY planning for children by citizens is not new. It began, for our country, when town meetings of colonial New England authorized establishment of schools for children, and made provision for binding out orphaned and homeless children with people who could give them shelter, food, and training or experience in useful work.

Emma O. Lundberg, in "Unto the Least of These," points out that almshouse care and apprenticeship or indenture "continued as the main systems of providing for destitute and neglected children for a great many years after the United States began its national existence."

Institutions for dependent and neglected children developed early in the history of this country, and were in part a response to recognition of the need for schooling and religious training for children, as well as being intended to provide the essentials of child care for those without homes.

Local concern for reducing the appallingly high rate of infant mortality led to the establishment of milk stations and infant-welfare centers, and in New York City to the founding of the first public bureau of child hygiene in the Nation.

Citizens demand child protection

Concern for protection of child workers and for removal of children from jails and almshouses, and recognition of the plight of ragged, homeless, and vagrant children on the streets of our great cities led citizens to demand child-labor and juvenile-court legislation, to establish societies for the prevention of cruelty to children, to found children's institutions and child-placing agencies, and later to make provision for public aid to dependent children in their own homes.

The establishment of the Children's Bureau in 1912 was in response to widespread citizen demand for such service in the Federal Government, a demand initiated in New York City by Lillian Wald, Florence Kelley, Samuel McCune Lindsay, and others.

For rural child-welfare services

The first work in the United States in developing child-welfare services in rural areas, available to help public officials, judges, and others to discharge more effectively their responsibilities to children, was started in New York State by the State Charities Aid Association, under the leadership of Homer Folks and H. Ida Curry. State boards of charity, departments of welfare, and State health agencies, as well as local voluntary agencies in various communities, have developed many pioneer services in response to citizen demand. Many national voluntary organizations have done and continue to do notable work in informing citizens of children's needs and enlisting their support and service in meeting them more adequately.

Extension of services to children in States and in the Nation as a whole happened because citizens had become convinced that children were in need of better protection, care, and opportunity, had found out through experience some of the ways in which they might be helped, and as a result saw the necessity for extending the services on a wider basis and for strengthening and improving the kind of services offered. Movements for improved State provision for children that swept the country in the first two decades of the twentieth century afforded the precedents for later demands by citizens for participation of the Federal Government in Nation-wide movements for the elimination of child labor, the protection of maternity and infancy, and, under the Social Security Act, cooperation with the States in extending and strengthening maternal and child-health services, services for crippled children, and child-welfare services, especially in rural areas and other areas of special need. The terrific emergencies created by depression and war accelerated these trends.

Voluntary organizations extend activities

As Federal and State services for children have been strengthened, the activities of many national and local voluntary organizations, both religious and nonsectarian, and of private foundations, have been extended, and continuing interest has been manifested in State and community planning in broad fields of human welfare and children's services. The 1919 White House Conference was the culmination of yearlong activities on behalf of children carried on under the name of "Children's Year." Some 11,000,000 women in 17,000 committees were said to have participated in this movement. State committees and conferences following the 1930 and 1940 White House Conferences, and wartime committees on children and youth, enlisted the participation and help of all agencies of State government concerned with children, and many citizen and professional

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Based on remarks made at the dinner meeting of the Children's Bureau Regional Conferences on Child Health and Child Welfare, held in New York City, October 19, 1950.

The child is the object of this great citizen endeavor, the Midcentury White House Conference, and his place in the family and in the community constitutes the focal point of it.

groups. Preparation for the Midcentury White House Conference on Children and Youth, focusing on consideration of the development in children of healthy personality, has enlisted some 75,000 people in State committees in every State and Territory, local committees and discussion groups in more than a thousand communities, and over 400 national voluntary organizations, as well as the agencies of the Federal Government.

The present White House Conference is an effort (1) to bring together the best that scientific discovery has to tell us about children in their growth from infancy to maturity and (2) to enlist the largest possible number of citizens in a crusade to provide better opportunities for children in their homes, neighborhoods, communities, and States. This emphasis on citizen initiative and citizen endeavor is in harmony with the central beliefs and principles of our democracy. No single uniform pattern prescribed by the Nation or the State is appropriate in a free society. The State and Federal Governments can help to stimulate, to coordinate, to spread information, to develop standards of care and quality of service and to encourage local citizens to find facts for themselves, to decide what needs to be done, to determine priorities, and to enlist support from their fellow citizens, drawing upon resources, public or private, for financial help and expert service, as seems appropriate to them.

Citizens accept a challenge

This concept of local initiative and local decision must be developed within a framework that assures that certain essential community obligations will be met and certain standards of service will be uniform throughout a State or in all States benefiting from Federal financial assistance. But the primary obligation of the local citizen to know and to act on the basis of that knowledge, and his freedom, within certain limits, to shape and direct the services rendered, in cooperation with his local fellow citizens, remains. For it is through experience in local self-government that the American learns to function responsibly in State, National, and international affairs.

Many graphic illustrations of the ways in which citizens accept a challenge to do their part in improving conditions surrounding children and opportunities open to them are found in the work of local and State White House Conference committees.

For example, in a mountain county of Kentucky, the local White House Conference committee decided upon a demonstration project for the county, selecting a small town in which to concentrate their efforts for a year. This would provide the county with a record of what could be done in a community on the basis of available resources and facilities. A subcommittee was formed of the citizens of this rural community. They have been extremely active. A large community meeting was called to decide upon a plan of action, and 200 were present out of a population of approximately 300.

A community uses self-help

The accomplishments of this small community are impressive. The only access to the school was a dangerous swinging bridge over a creek. This has been repaired, and plans are under way for completion of a safe low-water bridge. Wiring has been completed, providing electric lights for the school. Sanitation was a hazard. Plans for the improvement of toilet facilities have been made, as well as for screening the school windows. As a step toward initiating a hot-lunch program, this committee has held meetings in which nutrition films have been shown. A nutritionist has been asked to speak on several occasions, and is helping to prepare their project. Water previously was gotten from the creek down the hill. For a safe supply, a well is to be dug close to the schoolhouse. In order to raise funds for this ambitious program, the community gave a box lunch at which $275 was raised. Lumber for the building of the lunchroom has been donated. The citizens are volunteering their services to build it. In short, this small mountain town is a picture of a community going to work to meet the needs of its children.

Youth council makes survey

In one city-county group, located in the north central region of Kentucky, the county committee on children and youth is composed of a council of youth organizations, with an advisory committee of adults to work with them. The council is making a county-wide survey, and it foresees the setting up of a community council as a clearinghouse for all professional and private agencies who work with children. The long-range objectives of this White House Conference committee are: A kindergarten system, mental-hygiene clinics,

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day-care centers—all with activity programs centered on child development.

The programs for which State and local health and welfare agencies, both official and voluntary, are responsible have a very important relation to the central purpose of the White House Conference. They provide resources and services that are indispensable to the growth and development of children. They have made great contributions to the remarkable reductions in maternal and infant mortality and the improvement in child health that have taken place in the 15 years since the Social Security Act was placed on our statute books. Together with the professions concerned and the citizens responsible for rearing and educating children, these maternal and child-health services have cut down tremendously the incidence and seriousness of many childhood diseases. The crippled children's services have provided means for rehabilitating many thousands of handicapped children. Public welfare departments have administered programs of financial aid providing an underpinning for the family life of millions of children, at the same time stressing the importance of shifting to social insurance as much as possible of the responsibility for providing such financial support. Through their child-welfare programs they have also developed services and resources for conserving homes threatened with breakdown, and assuring care adapted to individual needs for children who must be provided for away from their own families for long or short periods. They have improved services for the prevention and treatment of juvenile delinquency. They are directing attention to the problems of mental health and the needs of emotionally disturbed children.

In reviewing how far we have come in the last 15 years and what remains to be done, not only with regard to children but to all age groups, we find that certain outstanding problems emerge:

Local responsibility essential

In the first place, citizens have not yet acquired the habit of thinking and talking of health and welfare services as "theirs" in the same degree as, throughout our history, they have had a feeling of proprietorship of public or parochial schools. One reason for the difference, of course, is the universal impact of the school upon the citizen, first as pupil and later as parent. Only when we come to think of the local health department and its various services for children as "our health department" and "our services," and to have similar attitudes toward public welfare and other social services for children, shall we achieve the kind of local understanding, initiative, and support that is essential for the stability and lasting success of these programs.

The question of how to keep this sense of local proprietorship and local responsibility, and at the same time obtain State-wide coverage of services available to all persons in need of them, is a question that has received far too little consideration.

Two other questions are of the utmost importance: (1) How to relate to each other and strengthen the contributions of private medical practice, voluntary hospitals, and private health and social agencies, and public services for health, medical care, and social welfare and (2) how to organize and interweave the services of various functional agencies and professions so that they may gear into one another in the service of the individual.

Recent legislation benefits children

Many of these and other issues have been the subject of Nation-wide discussion within recent years. The Eighty-first Congress has given consideration to a wide range of proposals having an important bearing on the health, education, and welfare of our people, many of them directly related to the well-being of children and youth. Notable legislation recently enacted includes housing legislation, amendments to the Fair Labor Standards Act strengthening both the child-labor and the wage-and-hour provisions; provision for Federal financial assistance for school construction and operation in areas in need of help because of Federal activity; extending the coverage and benefits of the Old Age and Survivors Insurance program and strengthening the public-assistance provisions of the Social Security Act; and increasing Federal funds authorized under title V of the Social Security Act (Maternal and Child Welfare), to be fully effective next year, by 50 percent for maternal and child-health services, 100 percent for services for crippled children, and nearly 200 percent for child-welfare services. These amendments provide additional resources for citizens to draw upon, through their State agencies, in more effectively meeting the needs of their children and implementing the recommendations of local planning bodies working in relation to the White House Conference.

Plans differ in various States

The provisions of all three parts of title V of the Social Security Act call for extension and improvement of services on the basis of State plans. In the child-welfare section special stress is laid on community organization, and under a proviso inserted in the 1950 amendments the States are authorized, but not compelled, to utilize the experience and facilities of voluntary agencies in accordance with child-care programs and arrangements in the States and local communities. State programs vary, State by State, in accordance with particular needs, interests, and resources, and the financial provision and facilities and professional personnel that can be made available. Recruitment and professional training of personnel, and comprehensive staff-development programs, have been important features of State plans. These plans differ throughout the State, in accordance with local needs, initiative, and resources. Effective leadership has been given in many States to the development of comprehensive community planning and community organization, in which citizens, public and private agencies, professional groups, youth representatives, and representatives of various racial groups have had their part.

The essential characteristics of a free society can find expression in organized health and welfare programs only through a heightened awareness of individual responsibility for effective community services, development of skills in citizen action, and improvement in methods of community-wide organization for social purposes. We must increase the effectiveness of citizen participation in determining relative needs and priorities of service, sharing in financial support through taxation or voluntary contributions, and advising as to methods of administration. Many new and improved tools are at our disposal, including methods of assessing public opinion, conducting forums and discussion groups, reaching new groups hitherto not usually involved in community planning—such as parents of preschool or of handicapped children—and exercising the responsibilities of citizenship in the use of the ballot, in presenting needs to legislative bodies, and in volunteer service.

Many knotty problems involving the relationship of lay and professional groups, public and private agencies, and the cooperation of different professions and functional agencies in the fields of health, education, welfare, recreation, and religion can be solved through effective community planning, community organization, and citizen discussion and action. In the long run, these are the only ways by which a broad base of understanding and support of children's programs can be assured.

To reflect cooperative action

In this period of reviewing our programs with a view to extending and strengthening them with new resources made available, it will be well to examine our own methods of service to local community groups. Perhaps some form of continuous county or community case record is needed by State health and welfare agencies, which can reflect cooperation among State agencies and with representatives of voluntary agencies or citizens' groups. The White House Conference year affords an excellent opportunity for moving forward on the basis of the widespread citizen interest and participation enlisted by the conference.

For consideration by the conference

Some questions which need consideration are:

1. To what extent are State programs for child health and child welfare rooted in local planning for services, community by community? What official and voluntary agencies and citizens' groups participate in such planning? How and through what means?

2. What is the relation of State health and welfare agencies to local planning? How can they be of greater service? What staff is needed for this work?

Better human relations depend largely on how children are reared, on the affection and security they find at home, on the services and opportunities afforded them by the community.

3. How can State health and welfare agencies work more effectively with each other and with other State agencies and institutions, such as departments of education, universities, and the extension service, in promoting sound community planning and greater citizenship understanding and participation?

4. In fostering community planning, what use can be made of local committees engaged in fact-finding work for the Midcentury White House Conference on Children and Youth and the findings of these committees?

5. What methods are now in use for informing people in local communities of the services that are available or that might be made available under State health and welfare programs? Which of these methods gives greatest promise for further development? What new methods should be considered?

Advance in human relations constitutes the challenge of the midcentury. Upon such advance international peace, world understanding and cooperation, and the soundness of national, community, and family life depend.

Improvement of human relations depends to a very great extent on the ways in which children are reared, the affection and security they find at home, the services and opportunities afforded them by the community. The central question to which the White House Conference on Children and Youth is addressing itself is: How can we develop in children the mental, emotional, and spiritual qualities essential to individual happiness and responsible citizenship?

Toward the future of our civilization

The child is the object of this great citizen endeavor, and his place in the family and the community constitutes the focal point. The influences surrounding him, the experiences through which he grows toward maturity, will determine the future of our civilization.

Reprints available in about 6 weeks

MIDCENTURY WHITE HOUSE CONFERENCE GATHERS

MELVIN A. GLASSER

AFTER 2 YEARS of intensive, Nation-wide preparation, the Midcentury White House Conference on Children and Youth will go into session in Washington, D. C., on December 3. More than 5,000 citizens from every State in the Union will gather in the District of Columbia National Guard Armory. Five hundred of the delegates will be young people, who will participate in all sessions. Several hundred delegates from foreign countries will also be present.

This is the fifth White House Conference called to consider the well-being of the Nation's children. The first was held in 1909.

Experts to report

The Midcentury Conference will be opened by Oscar R. Ewing, chairman of the national committee for the conference. President Harry S. Truman will address the delegates at the major general session, which will be attended by Cabinet officers, Members of Congress, and other notables. At other sessions, Mrs. Eleanor Roosevelt, Margaret Mead, Allison Davis, Dr. Benjamin Spock, and Leonard Mayo will speak to the delegates. Many of the Nation's most distinguished experts on child health, education, and welfare will give the delegates a comprehensive summary of recent developments in their fields.

The purpose of this conference is to consider what we, as a nation, can do to provide each child with a fair chance to achieve a sound, healthy personality or, in other words, "how we can develop in children the mental, emotional, and spiritual qualities essential to individual happiness and to responsible citizenship, and what physical, economic, and social conditions are deemed necessary to this development."

In recent years a new concept of the needs of children has developed. Even if the recommendations of previous White House Conferences were eventually carried out, we know now that they would not be adequate. The new ideas in the making have to do with qualitative aspects of human relations. As research has proceeded it has become increasingly apparent that all who serve children—social workers, teachers, doctors, religious counselors—must carry on their work in a way that takes children's feelings into account if they are to accomplish their purpose fully.

In the years gone by, we have recognized that inadequate income, poor schools and poor health services, racial discrimination, and the like are handicapping to children, not only in themselves, but because they are contrary to the democratic ideal that every person is of equal worth. Consideration of these factors is important for the well-being of the individual and of a society that now, more than ever, stands in need of efficient workers and responsible citizens who are strong to protect its way of life and flexible and tolerant to cooperate with those whose ways are different. These are the challenges which will be dealt with by the citizens who attend the conference.

The delegates will include large numbers of teachers, clergymen, social workers, doctors, psychiatrists, nurses, juvenile-court officials, and others qualified by reason of their professional knowledge and experience. Equally important will be the even larger number of laymen: Men and women active in local civic affairs; representatives of labor unions; mothers and fathers who take the lead in parent-teacher affairs, in community-welfare work, and in other activities that touch on the well-being of our children.

For the first time in the history of these White House Conferences, youth itself will be represented. The 500 youth delegates will include leaders in urban and rural youth organizations, employed youth, young people who are physically handicapped, and several who live in children's institutions.

Among the foreign observers will be a delegation of 18 Germans brought to this country by the Department of State as a special project of the international exchange program. A group of Japanese will attend under the sponsorship of the Department of Defense. The Red Cross societies of eight countries are sending delegations. Students who are in this country on United Nations fellowships and a limited number of foreign visitors here to study child health, welfare, and education will also participate in the sessions.

The conference will meet for 5 days. It will be distinctly a working body in every respect. Its functions will be to study and appraise existing knowledge on healthy personality development, to indicate what research is necessary to fill the gaps in this knowledge, and to make specific recommendations for more effective use of the knowledge.

The reports of the four advisory councils of the conference have now been published and copies mailed to the delegates. These include the report of the national organizations on their programs for children and youth, the summary of the reports from all States,

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Melvin A. Glasser, Executive Director of the Midcentury White House Conference on Children and Youth, was previously with the American Red Cross. He is past chairman of the National Committee on International Cooperation for Social Welfare, of the American Association of Social Workers, and was one of the two United States representatives on the Permanent Committee of the International Conference of Social Work. In July 1950 he was elected President of the International Federation of Social Workers.

he report from youth, and the one from he Federal Government agencies. A ligest of the comprehensive fact-finding eport, prepared by some of the Nation's eaders in child health, welfare, and education, has also been issued. When he delegates arrive at the conference hey will receive an additional publication, an illustrated statistical chart book prepared by several Federal Government bureaus to define many vital aspects of the status of our children.

Five hundred young people will be delegates to the Midcentury White House Conference. They will include leaders in urban and rural youth organizations, employed boys and girls, young people who are physically handicapped, and several who live in children's institutions.

The actual work of the conference will be conducted through some 30 information panels and 35 work groups. The panels will set forth our present knowledge on the development of healthy personality and will indicate salient problems. Authorities in each field will discuss the bearing this knowledge has on all that is done with, and for, children. Each panel will have a leader and several experts qualified in various areas of the field of discussion. They will provide a basic point of departure for the recommendations of the work groups.

Half of these panels will meet on the second day of the session, the other half on the third day. Delegates will choose the panels they wish to attend or to which they feel they can make some specific contribution.

Panel subject matter will range from the concepts of personality development and their meaning for work with children and youth to more tangible questions of the effect of housing, satisfying work, and social security on the growth and development of children and young people. For instance, the crucial conflicts in personality development in youth and young adulthood will be given individual attention, as will the changing patterns in child-family-community relationship. The cost of living as a factor in the growth and development of children will occupy one panel, the differences in family income another.

Separate panels will also cover such matters as the effect of discrimination and prejudice, leisure-time activities, employment opportunities, community services, and a variety of other related subjects. And two panels will focus on the effect of war and mobilization for war on children and youth.

In addition to these information sessions, documentary films dramatizing various aspects of the subject matter will be shown. There will also be an extensive series of exhibits providing graphic demonstrations of some of this background material.

All this preparation is preliminary to the real work of the conference which will be conducted in 5 sections broken up into 35 work groups. Delegates will be asked in advance to specify, in the order of their preference, the particular group with which they would like to work. Final assignments, however, will be determined by the conference steering committee with a view to securing for each group a wide range of interest and professional experience. The number of delegates assigned to each work group will vary from 75 to 150.

How the five sections work

Each group will attempt to determine, in relation to its assigned subject, what experiences and conditions further the development of a healthy personality, and conversely what experiences and conditions are likely to hinder such development. They will also try to determine how the positive factors can most effectively be established in a child's life and environment, and how the obstacles can be overcome or negative factors eliminated.

One section will attack the problem in terms of age groups: Infancy and early childhood; childhood; preadolescence; young adulthood; and, in general, birth to adulthood.

Another section will examine the ways in which the social institutions—the family, the church, the school, social welfare, health services, recreation, and informal education—are serving children. The relationship of the child to law-enforcement agencies and the various protective services will also be carefully explored.

Another section will deal with the influence of religious, social, and economic forces. Here the effect of conflicting standards and values—spiritual and material—will be discussed: The effect of too much or too little income, of neighborhood "climate," of prejudice and discrimination. The influence of radio, television, comic books, and other mass media will be explored, as well as the tensions engendered as the Nation moves increasingly to mobilize its resources for defense.

Still another section will discuss the obstacles to be overcome for children with "part-time" parents, children of migratory parents with no permanent home, children with some physical or mental limitations or emotional disorders, and children who have rebelled against authority. Here also will be considered the extent to which a child's personality may be warped because of poverty.

The fifth major section will try to find out how to achieve the most meaningful citizen participation in activities for children and youth—how the needs can be assessed, planning projects inaugurated and carried out, the energies of business, labor, civic, and other special groups of workers enlisted, and what contribution can be made by professional workers. And of final importance, what kinds of organization—at National, State, and local levels—will best facilitate citizen participation and community action to implement the recommendations and other findings of the conference.

Reports to include data from work groups

The specific findings and recommendations of each work group will be incorporated in the five section reports to be presented at the closing general session of the conference. These reports and the recommendations drawn from them will represent the major conclusions of the conference.

While the reports are being compiled, a series of meetings will be held to gather together delegates of like professional interests. The purpose of these meetings will be to bring into focus the relation of, say, the nurse, the doctor, the teacher, the social worker, and so on, to the entire problem of personality development. These sessions will help the delegates direct their own professional activities more effectively toward concrete objectives in the solution of common problems.

A day before the opening of the conference a special meeting will also be held to orient the several hundred foreign observers attending the conference as to the problems to be discussed. Immediately following the conference the group from other nations will meet for 2 days to discuss the findings of the delegates in relation to their own problems of child care and development.

The foregoing summary serves, in some degree, to describe the scope and operation of the Midcentury White House Conference on Children and Youth and to explain the tremendous significance attached to it. But it does not even begin to suggest the vast amount of effort that has gone into its preparation for the past 2 years, or the grass-roots activity in which it is grounded.

Over the past 2 years, under the direction of the national committee of the conference, this work of preparation has been pushed steadily forward. At the request of President Truman all the governors of the 53 States, Territories, and possessions have appointed official White House Conference committees. These committees have been unusually successful in stimulating local discussions, inquiry, and activity throughout the country. Several hundred national organizations concerned with the interests and welfare of children have focused a large share of their attention on these problems of personality development. Youth organizations have explored the matter from the angle of their own particular interests and experiences. Some 40 departments and bureaus of the Federal Government have marshaled their technical skills and resources to project a series of special studies in this field. And more than 150 State-wide meetings have been held, with large and enthusiastic attendance.

Facts studied by communities

Under the impetus of the State committees, local fact-finding programs have been initiated, designed to gather factual information relating to the central theme of the conference. Working with these committees have been some 15,000 specialists and consultants. Neighborhood groups have studied specific community conditions and needs and reported their findings. Altogether, some 100,000 lay citizens—mothers, fathers, and others deeply concerned with the problems with which the conference will deal—have served on committees or have otherwise been active in preparation for the conference.

The net result has been an impressive round-up of important data developed locally throughout the Nation. Much of this factual material has been incorporated in the State surveys, which spell out in considerable detail the "children and youth problem" as it exists within the borders of each State. No comparable body of information has ever before been gathered. It constitutes the soundest possible basis on which an important conference could proceed.

No one factor entirely responsible

While the conference theme implies that many of the major problems of children today are psychological, it is not meant to imply that the causes of these problems are necessarily of the same nature. Emotional ill-health may have economic, sociological, psychological, physical, or spiritual causes. We know that inadequate food and housing, racial discrimination, physical illness, lack of spiritual values, as well as insufficient love from parents, may handicap a child's personality development. Nor are these various explanations of personality maladjustment to be considered as secondary to the psychological. While scientists are still far from knowing the whole answer, it is increasingly evident that many factors are involved, no one of which is dominant.

We still have much to learn

In undertaking to examine the present situation of our children with respect to their personality development and to consider measures that might be undertaken to improve it, many ideas and practices will be taken into account during the conference. Such diverse matters as economic resources, the insights of religion, esthetic expression, law and custom, and many others, will be considered. And the work of all the social institutions that have received the attention of previous conferences will be reviewed.

It is recognized that in all these matters there is still much to be learned. We are far from knowing exactly how personality development proceeds, and precisely what influence various factors have upon it. Nevertheless, much is known that is basic to health and happiness. The challenge to the times which is offered to the December meetings is how to put this knowledge to work—for the benefit of our children and ourselves and of people everywhere.

AFTER THE MIDCENTURY WHITE HOUSE CONFERENCE—WHAT?

MILTON J. E. SENN, M. D.

Early experience figures largely in forming the adult personality; and the greatest influence is that of the mother, or whoever takes her place in caring for the baby from birth onward.

IT WAS with mixed feelings that I accepted the invitation of the Executive Committee of the Connecticut Commission on Children and Youth to meet with you today. You will understand the reasons for this when I remind you that the invitation came in mid-August, when the war in Korea was still in its ascendancy, when the armies of the United Nations were losing ground, and when we were all grimly reminded to prepare for another world conflict. Already the press had taken up the theme of preparedness, not only in terms of material supplies and the readying of armies, but also of psychologic preparation, printing stories of those other peoples whom as enemies we were now to distrust and to hate, and if necessary kill. All of this killing, it is true, would be in self-defense; but to those of us who prefer to love rather than to hate, who prefer peace over war, whose aim is to prepare others for living rather than planning their destruction, this new turn of world events was depressing. And so in thinking about your invitation to speak about what might be done for our children and youth toward helping them to develop into a mature generation, thoughts of futility and despair added to my depression. It seemed pure hypocrisy for me to spend time, thought, and effort in preparing a paper for this meeting, when instead I should be helping to recruit our youths for warfare, and preparing them psychologically for a maturity which some of them were to be precipitated into overnight.

My final decision to accept your invitation was no doubt prompted by several reasons. I believe my primary reason lay in the fact that I hoped to keep my own peace of mind, in turning away from thoughts of destruction to those of planning constructively. This sublimation of mine is an important mental mechanism, which all of us, in our own way, must use if we are to survive this dark time. Modern dynamic psychology teaches that we use such protective devices unconsciously all the time. It also teaches that inaction fosters fear, whereas action, planning, and thoughtful appraisal of one's danger prevents anxiety.

Many philosophers have taught that when men are in imminent danger of destruction they should try to live not for the minute, the day, or even the year, but in eternity. Philosophers and theologians, and now the psychiatrists of today, have taught that those who learn to live nobly in service to others find that it takes away the panic quality of misfortune and prevents anxiety which borders on madness and leads to overwhelming disaster.

On further reflection on the value of planning constructively I came to the conclusion that in terms of the needs of children of the world, such preparation for peaceful living was more than a preventive of personal madness; I concluded that the establishment of standards for a better life for our children, and their parents, might constitute a counteroffensive on a health and social-economic level which could be as powerful as that carried on by arms and instruments of war; and it seemed to me important to strengthen our war-allies not only through sending them guns or teaching them methods of armament making, but further to see to it that those peoples, along with ours, gained an improved standard of living

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Dr. Milton J. E. Senn is director of the Yale University Child Study Center. Dr. Senn presented this paper at the Governor's Conference on Children and Youth, held at St. Joseph College, West Hartford, Conn., September 22, 1950, in preparation for the Midcentury White House Conference on Children and Youth (December 3-7, 1950).

through enlarged opportunities of many kinds.

But in this counteroffensive there also needs to be preparation; and I would like to think that in today's conference we will consider together what in this State might be done for children and youth that would serve as an example of the manner in which to achieve higher levels of well-being, physically, emotionally, and spiritually. I have the conviction that we are now establishing in many areas of American life precedents that may rule our Nation, and other nations, for years to come. If this is so, we must be wise in our planning. For this reason it is imperative that the White House Conference serve as a rally place for appraisal of what is known, what is being done, and what should be done in the fields of child care, child rearing, and other related areas. It is particularly fitting that the conference focus on the development of the healthy personality, since today on every hand we see evidence of psychologic breakdown, with all manner of suggestion as to how to prevent this from happening, and what to do therapeutically in overcoming these disabilities.

A fair chance for emotional health

For the past year and a half I have attended many meetings called by members of the United States Children's Bureau to make preparations for the conference in December. Through all of these I have had the feeling, increasingly, that the conference has already paid dividends in pointing out lacks in our knowledge and delineating areas for change and further study. More than once in these meetings some participant has asked, "But what is meant by a healthy personality?" and in response there has always been a multiplicity of replies, and often wide disagreement. Conclusions have always been reached that it is easier to define disease than it is to define good health, and that it is easier to describe what goes into the formation of an unhealthy personality than into the development of healthy and mature personalities. With these experiences behind me, I was pleased that your executive committee limited my topic today to a discussion of what might be done toward "Helping Children So That They May Have A Fair Chance For a Healthy Personality." Accordingly, I do not feel called upon to describe a specific formula which would guarantee to every child the development of a personality of the highest order, but rather to consider in general terms those elements which offer a fair chance for the acquisition of emotional health.

What do we know about healthy personality?

Let us consider, then, for a short while, what is accepted as correct knowledge about the healthy personality, even though we must get at this at times through an appraisal of the unhealthy personality.

Psychiatrists and social scientists seem in agreement in considering personality as an aggregate of forces which gives to a person his sense of identity, and which relates continuously the inner workings of himself with events on the outside, with the result that each individual possesses individuality and distinctiveness. To obtain optimal development of a personality, then, there must be healthy inner resources which have full opportunity for relationships with the outer environment.

Since all these elements are everchanging, it is apparent that a personality is never fixed nor static, and it must be prepared always to meet minor as well as major alterations both within the person and outside himself. For example, the healthy personality in peacetime must, in this day and age, be capable of shifting into that state which can deal effectively with conditions of war. This changeover can be done more easily by some individuals than others. Just why this is so is not certain, and it is one of the things we would like to know about personality development. But the example I give emphasizes that mental health, like physical health, is relative. The healthy individual in peace who is not able to adjust as rapidly to the reality of a war system may show symptoms of physical and psychologic illness. We diagnose this as a breakdown of his personality. But such happenings, which appear too frequently in our soldiers, whether they reach combat or not, to my way of thinking does not mean that such an individual basically is weaker than his fellow who is more easily able to adjust from peace to war. Those who disagree with me recommend Spartanlike regimes for child rearing to prevent such breakdowns, in the belief that today our chief efforts in child rearing should be to make all our male children psychologically ready for war and army experience.

Such critics do not look with favor at some of the current infant- and child-care practices which others of us consider good physical- and mental-hygiene practices for peaceful living with fellow human beings, practices which are concerned with the individual in terms of helping him to obtain emotional gratification as well as physical strength, and in helping him to reduce those everyday conflicts between his inner self and those of society outside of himself which, if not reduced, lead to a variety of somatic and psychologic ills.

To return to the concept of personality as the resultant of a number of relationships between the inner self and the outside world, it may be said that little is known about the inner part, how dependent it is in its development on hereditary, genic factors, and how much constitution plays a role. Although little more is known about the outer part or the environmental factors which are in a process relationship to those inside the person, it is conceded by students of personality development that the most important part of the environment is that represented by other human beings, and that the environment which is significant for healthy personality development is that of satisfactory interpersonal and social relationships.

How personality develops

What has just been said may be viewed schematically as follows: Personality development has a biologic beginning at conception, and goes through various stages which, for convenience, we call prenatal, neonatal, infancy, preschool, or school periods, followed by puberty and adolescence and adult maturity. Each of these stages is everchanging and is the resultant of the interplay of certain hereditary and constitutional endowments within the person, with many environmental forces, such as influences within the family, the natural world, and organized society.

It is essential that professional people who guide parents, who minister to children, should look beyond the physical needs and recognize the importance of the emotions and the spirit.

The early life experiences of the person seem to play an important role in forming patterns of the adult personality structure. The impingement of the personalities of parents, siblings, grandparents, teachers, physicians and nurses, ministers and priests, and others is important, with the most important influence being that of the mother or her surrogate who cares for him from birth onward. Environmental influences also include cultural forces, which in their variety and intensity are evershifting. And finally, there are those important social and economic elements which also fashion and modify personality in particular ways.

It is not that I am unmindful of the profound effects of genic and constitutional factors in determining personality, that I bypass them now and focus instead on the influence of environmental factors. I do this because very little is known about human heredity and constitution. These represent some of the areas that will be emphasized at the White House Conference and in preparations made for their study in the postconference period.

I would like to spend most of the remaining period of my discussion in mentioning briefly what is known clinically, if not experimentally, about the relationship of the developing human personality to environmental influences. A good place to begin is the prenatal period. Science long ago demonstrated the importance of a healthy physical environment for a developing fetus and its mother; the modern prenatal clinic focuses on maternal nutrition, blood study (serology and the Rh factor), pelvic measurement, breast care, and so forth. What is not recognized enough is that the pregnant woman has interest in and feelings about other things than just the physical. Anyone who has taken time to listen to pregnant women and their husbands realizes that the average woman and her husband approach parenthood with mixed feelings, that there is much self-examination, with many doubts and fears about their ability to successfully produce a healthy child, and to rear him satisfactorily.

Expectant parents need to be reassured

The reasons for some of the anxiety I will not go into at this time. Instead I would like to emphasize the fact that people approaching parenthood have these feelings, and that they want help, not only in the area of physical care, but also in that of the emotions, as they seek persons to whom they may talk and express their feelings, ask questions, and receive supportive reassurance. Where such people find among their professional advisers physicians and nurses who are sympathetic listeners, there comes to the average pregnant woman a greater feeling of courage, so that she is able to go through pregnancy and delivery with less anxiety and discomfort, and with even a smaller dosage of anesthetic.

But what is probably more important is the situation seen clinically where expectant mothers are able to assume a healthy dependency relationship to their professional advisers, as well as to their husbands, and through this are able to understand that people are interested in them and care for them. All this assists them in setting up more readily their own loving relationship with their offspring. Such a mother is able to respond to her baby naturally, and biologically is better able to understand his needs. She will then be able to institute child-care practices, particularly feeding and training, which are centered around a happy relationship of mother and infant, so that she will be able to satisfy the infant's needs in a manner that he early interprets as representing love, and he will become conditioned in the belief that the persons who provide these satisfactions love him.

Love important to infant's well-being

Out of this relationship, in which the infant is the recipient of love, is born the ability for him in turn to love others. Love is an active state which is learned by the infant, and it is a state which is developed in dependency. And although the pattern of love based on dependencies is maintained throughout the life of the person, it must be emphasized at this point that the love which a parent has for his newborn infant can be provided in fuller portion if these parents in the prenatal period, and at the time of delivery, and immediately postnatally, are able to feel (like their infant) that they too are loved. It may seem to you that I am overstressing the importance of love, but it has been interesting to me to see within my professional lifetime how the scientific world in medicine, biology, and other sciences are in agreement increasingly with their colleagues in theology and philosophy who have so long seemed alone in emphasizing the role of love in human behavior and emotional well-being.

Believing these things, you will see why I am desirous of learning from you what is being done in the State of Connecticut to insure pregnant women and their husbands not only good physical care, but also optimum psychologic benefit. What are the physicians in this State doing in their private practices and in the public clinics in providing prenatal care which includes consideration of the emotions as well as of the physical needs? What are the State and local departments of health doing through their physicians, nurses, social workers, nutritionists, and all the other members of their staffs, in providing psychologic care which is concerned with the whole person instead of a few of his organ systems? What are we doing in our hospitals in helping patients and their relatives go through hospital care with a minimum of physical discomfort and anxiety? What are we doing in helping parents learn early child-care practices which bring parent and child closer to each other, and yet does not lead to separation of husband and wife?

The infant learns that to be satisfied, to be loved, he too must satisfy, and he too must love. It does not take him long to know that he must measure up to the requirements of others, particularly his parents, and that he must cooperate, and that on occasion he must give up or delay the satisfaction of pleasures which he wants for himself if he is to achieve gratification out of his relationships to other people, and if he is to retain their love. These early experiences with his parents set the pattern for what he will be as an adult. It is from these early experiences that he learns to get along with other people, that he appreciates the fact that through love as a feeling of belonging he becomes more secure, and that through love from people in authority he in turn can learn that authority does not mean loss of affection. What we would like is for the infant to be cared for by people who love him, who can express authority without threatening him too much with loss of love.

He needs to feel that he belongs

We know that some threat of loss of love is inherent in the growing child, even though it is never emphasized directly or deliberately by the parent as a means of enforcing authority. But what we would like is that the infant grow into childhood with a feeling that his parents love him even though they limit him, even though they do represent supreme authority. There is ample evidence that this feeling is developed best in the child who early gets the feeling that he belongs to a family. Where a child does not have the opportunity of belonging to a family, there is a tendency for psychopathology of some variety or another to develop. Students of delinquency have constantly pointed out this fact. I need not point out to you the importance, then, for all of us to plan those child-care practices which develop family unity and insure a continuity of relationship between a child and his parents from birth through adolescence. It may not always be possible to do this. When this happens we are called upon to provide family substitutes for the children. This is best done through foster homes.

For emotionally disturbed children

One of the topics of concern at this conference today should be in the area of foster-home care of children. What are the needs and the problems? And where foster homes are not available, or do not serve as suitable substitutes, we are faced with the responsibility of finding other substitutes. In this regard I cannot help but mention that some of us have been working on a particular problem in this field, namely the establishment of the Connecticut Child Study and Treatment Home for emotionally disturbed children who are unable, because of their emotional illness, to live with their families and who need psychiatric assistance in a healthy environment. Those of us who have been charged by Governor Bowles to carry out the act of the 1949 legislature in establishing this home, have felt the great responsibility placed upon us. In passing may I just comment that the board of trustees of this institution is proceeding in its planning in what we consider a satisfactory manner. But we are also convinced that the real success of this venture will come only if we have the sustained assistance of the executive and other branches of the government, and of the citizens at large. It is our belief that when this institution is finally engaged in the care of children, all of you will be proud of the foresight and pioneering endeavors you have made in this direction, and that you will be able to point to this child-care resource as an example of what people of other States and other countries should aim for.

I have mentioned that deprivation of love felt by an infant during the early years of his life may lead to inability to develop social proclivity, and that there is ample evidence to show that one learns to love by having been loved. Or saying it another way, society arises out of love. Love develops out of the gratification of one's need for self-preservation and is achieved through our primary dependent relationship to our parents; but in order to continue to develop socially in a satisfactory manner the human organism requires also the presence of other persons or their substitutes whom they may love and who will reciprocate with love. Out of this love comes a feeling of security. This is what the human being seeks all his life. If he seeks security in a material sense, he soon learns, like the infant, that mere satisfaction of basic physical needs is not enough. Needs must be satisfied in an emotional as well as in a physical sense. The emotional need for love is as urgent as the need for food.

Technical skill not enough

It is essential, then, that our professional people who guide parents, who attend children, who make laws about children, who educate children—in fact, who do anything for children—be prepared to look beyond the satisfaction of physical needs and have firm belief in the philosophy that consideration of the emotions and the spirit, if you will, is important, and in fact must go hand in hand with care of the physical being. Being a medical educator, I cannot help but look at the training of our medical students and of the young women in schools of nursing and ask if we are placing primary emphasis where it is needed in the teaching of these young people who come to us for technical training, but who are charged with the care of human beings that goes beyond mere technical skill.

I have recently made a survey of undergraduate medical education in this country, and I am impressed with the present-day emphasis on turning out more physicians, but without adequate consideration for the quality of the physicians we are developing. I am appalled at the increase of enrollment in some of our medical schools without a proportionate increase in faculty. It is to be regretted that the average medical student, on completion of his 4 years of medical training, seems to be less sensitive to the emotional needs of his patients and to his civic and community responsibilities than he was when he first entered medical school. It is as if in our scientific training we have mechanized him and given him an impression of the human organism as one made up in various chemical laboratories, without feelings and emotions. As a result, the modern well-trained physician frequently tends to be impersonal to the point of being unfeeling. Fortunately in some medical schools there is now recognition that this kind of physician is less effective in even the physical management of his patients.

Schools need to teach human relations

I have said before that what is needed is a change of attitude of people who deal one way or another with children and their parents. I must emphasize that one of the most important groups of this kind are the teachers in our schools. It will be interesting to hear from the various subcommittees charged with surveying the schools of this State to learn what the deficiencies in our school systems are, what is being done to correct them, and what should be done further. As a fairly recent newcomer to this State, I have been greatly disappointed in some of the public schools I have come to know. Probably what is more serious is the apathy on the part of citizen groups to the needs of the pupils and of the teachers. I have been distressed by the lack of understanding of some of the leading newspapers of this State, as demonstrated through their repeated attacks on the State department of education, the State government, and others who have been working toward an improvement of the practices of education. I have learned that there are communities in this State whose citizens are quite willing that the education of children be restricted to learning the three R's, and who have not seen the opportunity of teaching them about human relations. It has been pointed out by others, better than I am able to, that the school is a natural place for unorganized instruction in human relations, from the principal to the janitor, and that learning here by example and imitation can be carried out to a high degree.

It is important, then, for all personnel in our schools to believe in the right things, so that unconsciously and consciously they may be able to teach friendly human relations through their own relationships with children. It has been charged that in our country today some teachers are teaching race prejudice to their pupils. They do not do this through special courses, or even by words alone, but rather by facial expression, mannerisms in conduct, and inflections of the voice. No person should ever be allowed to become a teacher unless by temperament, attitudes, physical health, and training he is fitted to do so. The teacher is one of the most important of all the public-service personnel in a community, because he has the opportunity of molding and channeling the behavior of children who will one day become citizens, and who should be able to carry on the responsibilities of good government in a healthy society.

To train children in the art of living

Without in any way devaluating the important influence which the home affords, the school must be considered as the next most important agency in the teaching of human relations. Are we ready to shift the emphasis from the three R's to that of human relations, and place it first in the rank importance as the chief reason for the existence of the school? It has been demonstrated in school systems in this country that training for humanity and training in reading, writing, and arithmetic can go hand in hand so that the pupils are able to use their knowledge in ways that serve humanity. Some one has said that all the knowledge in the world is worse than useless if it is not humanely understood and humanely used. We have learned from the dictatorships abroad how intelligence that is not humane may become the most dangerous thing in the world. It is important, therefore, that our teachers be particularly fitted to teach human relations through their professional and personal relationships to pupils. The importance of their roles in this way must be recognized and encouraged, and further must be suitably compensated by society, which should endeavor to get into the teaching profession the right kind of people who are able to prepare human beings for the art of living. To me there is no more important task than this.

A short time ago I mentioned that in the environment of the growing child there are cultural and social-economic factors which also influence his personality. Unfortunately in our society, both in the schools and in the business world, there are times when impersonal interest in economics overshadows interest in humanitarianism, and competition replaces cooperation. In the setting of the schoolroom we have found that such substitution may

At any age, the child's emotional need for love is as great as his physical need for food.

Many different environmental factors enter into the development of a child's personality.

lead to learning difficulties, or to frustration of children which manifests itself in hostile behavior, or even truancy and delinquency. I am not sure what we can do about a society-at-large that places material values over those of the spirit, and which presses teachers and others who care for children to think in terms of dollars and cents, and competition, rather than of human relations in which there must be cooperation. I do not have remedies for a society which on the one hand preaches brotherly love and on the other hand practices denial of brotherhood. Certainly we see the result of this teaching in the conflicts of our children. In fact, it is usually our children who point out these discrepancies to us, since they are able to see so clearly the falseness of our values, whereas we as adults seem to have become blinded to our own hypocrisy. As one observes infants and children in their development, he is struck with their desire to love their fellow human beings.

For a better society

Again the philosophers and the theologians have pointed out the tragic disparity between what we do as children, and what as adults we practice in human relationships. As I have just said, I do not know the remedies, but I would be remiss if I excluded from my consideration of the development of the healthy personality the influence of social and economic elements, which in their present form have been held responsible for the sickness of our society. It is popular today to talk of social engineering, and one cannot escape the idea that the social engineers of the future are our children. But how are they being prepared for their task? Are they being taught soundly what the nature of our society is and how our democracy may be improved?

It seems to me that this must be an important item on the program of planning for our children, that they learn to look at themselves and each other and the world in which they live, without bias and with great objectivity. But in order for them to do this it will take leaders who have courage and who have an interest in all human beings, of all mankind. This will call from all of us many attributes, of which courage and conviction stand paramount. Against us there will be many handicaps. I have already mentioned one of the outstanding ones, namely, the apathy and inertia of our citizens; and, along with this, one must list the fear of failure and the resignation to defeat. However, as I said at the beginning, for our own peace of mind it is important that we make the attempt to change those practices and institutions which we know prevent the development of the human being to his full capabilities.

If we believe in the soundness of our cause and in the need to improve our world, I hope that through the White House Conference we will be able to band together for concerted action, in order that we may convince others of the value of our program, and of the benefits which will come to mankind through new approaches in what is done to human beings. Unless something like this follows the conference, I believe it will not have served its chief purpose. We must not get the notion that one thinks of these matters only every 10 years, when another White House Conference is called. I hope that within this State there will be some kind of active, permanent group to press for the causes of children and their parents. I would like to propose that the establishment of a Citizens' Committee for Children, representing different professional and lay groups, be considered, so that sustained and unifying assistance may be given to our representatives in the State government as well as to persons in the community at large. This is not to deny the need for all existing professional and philanthropic groups interested in child welfare to remain actively engaged in improving their own work. However, in spite of the many advantages of specialization, this has often led to a splitting up of thought and activity among highly concentrated specialized groups, each making too little effort to interrelate its work with that of others, and with a tendency to speak entirely different languages, and to view each other with satirical scorn. There is need for sound long-range, integrated planning on a State-wide basis for the total needs of all children—whether sick or well.

Modern war, as terrible as it is, has demonstrated how fully separate units in science and in other disciplines, along with business, the press and radio, and our citizenry generally, can join forces, raise billions of dollars (which yesteryear were not available for use in education because the "costs were too high"), and cooperate for a common end. It is unfortunate that the end is self-defeating, because it destroys the flesh and the spirit. But why cannot these same groups of people cooperate as completely for total good as they can for total war? In large part, the answer lies in each of us individually. Where do you stand?

Reprints available in about 6 weeks

• IN THE NEWS

IRO Appoints Pediatrician

In order to safeguard the health of refugee children 5 years and under, who comprise almost 17 percent of the DP population under its protection, the International Refugee Organization has appointed a French pediatrician, Dr. Pierre Straus, as consultant to its headquarters staff in Geneva.

The high percentage of very young children in IRO installations, twice that for the same age group in the United States, has posed a number of difficult problems for the UN specialized agency.

Mass transportation problem

The greatest problem to be solved is mass transportation involving children, who are most vulnerable to infectious diseases during movement. An immigrant DP family, leaving Italy for Australia, must travel by train to Bremerhaven, Germany, the IRO's port of embarkation, and then make the month-long sea voyage through a variety of extreme climate changes.

Preventive measures instituted by IRO's Health Division include temporary immunization against measles, standardized baby-feeding programs, and the installation of baby kitchens in IRO ships. In addition, infants are not permitted to make the arduous ship voyage to Australia, via the Red Sea, during the summer months.

Chief dangers

Chief dangers for the young refugees are rickets and respiratory diseases. Their incidence among the DP's, however, is no greater than the rate among the resident population in the West European countries.

First Children's Hospital in Bolivia to Open With Aid of WHO, UNICEF

The first children's hospital in Bolivia is now being erected in La Paz by the Government of Bolivia, according to the Pan American Sanitary Bureau, Regional Office of the World Health Organization. The 200-bed hospital is being built with the technical advice and assistance of the WHO Regional Office and the financial aid of the United Nations International Children's Emergency Fund, which is contributing toward the purchase of equipment.

The institution is designed to render a comprehensive program of hospital care for the children of Bolivia and to provide for the teaching of pediatrics and the training of pediatricians to serve the entire country. The hospital will have ample facilities for outpatient services, a modern dietary department, laboratories, X-ray department, medical social services, and surgical suites.

As one of its important components, the hospital will have a 50-bed section devoted to infectious diseases, to be operated under modern isolation techniques. Parents and other visitors can see and speak to the isolated children through a glass partition provided with a gauze-screened mouthpiece, which maintains complete separation between child and visitor, thus avoiding the danger of contagion.

A modern auditorium, suitable for use as a theater for film showings, or as a conference or meeting room, or as a lecture hall, will be another feature of the new institution. It will be used by the medical profession, technicians in related fields, mothers' clubs, parent-teacher associations, and the general public as a headquarters for conducting health-education programs, especially in the field of maternal and child health.

• CALENDAR

Nov. 29–Dec. 1—National Conference on Labor Legislation. Washington, D. C.

Dec. 3–7—Midcentury White House Conference on Children and Youth. Washington, D. C.

Dec. 26–28—American Association for the Advancement of Science. Cleveland, Ohio.

Dec. 27–29—American Statistical Association. Annual meeting. Chicago, Ill.

Dec. 27–30—American Economic Association. Annual meeting. Chicago, Ill.

Dec. 28–30—American Political Science Association. Annual meeting. Washington, D. C.

Dec. 28–30—American Anthropological Association. Annual meeting. Berkeley, Calif.

Jan. 18, 1951—Maternity Center Association. Annual meeting. New York, N. Y.

Jan. 24–27—American Association of Schools of Social Work. Annual meeting. Toronto, Canada.

Jan. 26–27—American Group Therapy Association. Annual conference. New York, N. Y.

Area conferences, National Child Welfare Division, American Legion:

Jan. 5–6, 1951—Area D—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. Minneapolis, Minn.

Jan. 11–13—Area E—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. Billings, Mont.

Feb. 2–3—Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, and West Virginia. Niagara Falls, N. Y.

Mar. 2–3—Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Columbia, S. C.

Mar. 9–10—Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, and New Hampshire. (City not determined.)

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THE CHILD

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• FOR YOUR BOOKSHELF

THE ARTS CO-OP SUGGESTS TOYS FOR CHILDREN. The Arts Cooperative Service, Inc., 340 Amsterdam Avenue, P. O. Box 152, New York 24, N. Y. 8 pp. Mimeographed. Single copies free.

A nonprofit association, formed to further an active type of education, offers this catalog of playthings for young children and leisure-time materials for older children.

The list is divided into five groupings: (1) Making music, (2) playing with color and form, (3) everyday life in play, (4) making things, and (5) finding out. The age group for which each toy is appropriate is given, as well as practical details such as size and finish.

AUDIOLOGY, the Science of Hearing; a developing professional specialty, by Norton Canfield, M. D. Charles C. Thomas, Publisher, Springfield, Ill., 1949. 45 pp. $1.75.

In a series of brief chapters, this book gives a clear and simple explanation of the modern approach to the hard-of-hearing adult and child. These chapters state the problem of persons who are hard of hearing and discuss the contribution to audiology made by the several professional disciplines and the services that are provided in an audiology program.

The chapter on pediatric audiology is an effective statement of the meaning for children of this new science, which was developed during the war years. It is, after all, among children that our greatest opportunity lies, both for preventing loss of hearing and for minimizing the adverse effects among those who are handicapped. Dr. Canfield states: "Hearing aids for children have been a great boon. Witness the happy, playful child who is able to do everything a normal child can do, and you will at once be convinced that to have such children in a regular school is far superior to having them in a deaf school or a class for the physically handicapped. Children use hearing aids extremely well, and their speech need not deteriorate; their life is full, and not warped by the unfortunate environment necessitated by other programs for their education."

This book is a valuable introduction to the modern concepts in the field of hearing, and speech as related to hearing.

Arthur J. Lesser, M. D.

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THE MAKING OF A HEALTHY PERSONALITY

U. S. SUPERINTENDENT OF DOCUMENTS
26 1951

Highlights From the Fact-Finding Report to the Midcentury White House Conference on Children and Youth

A NEW CONCEPTION of children's needs has developed . . . . This new way of looking at children's needs leads to the conclusion that demeaning poverty, inadequate school and health services, racial and ethnical discrimination, and the like, are handicapping to children not only in and of themselves but also because they are contrary to the democratic ideal that every person is of precious and equal worth. The presence of these conditions arouses feelings of uncertainty and inferiority, envy and resentment. Quite aside from the individual, humanitarian aspects of the matter, these are serious consequences for a society that now more than ever stands in need of efficient workers, clear thinkers, loyal citizens, who are strong to protect its way of life and flexible to cooperate with those whose ways are different.

Emotional ill health may have economic, sociological, physical, psychological, and spiritual causes. A child's personality development may be handicapped by inadequate food and housing, racial discrimination, physiological malfunctioning, lack of spiritual values, as well as by insufficient love from his parents.

We have . . . a bit of the philosopher's definition in our concept: the notion that the personality is an inward awareness of the self as permanent and unchanging. We take from the physiologist and the psychologist the idea that the personality is the organism itself in its most complex functioning, a system of reactions, physical and emotional, that has continuity but is indefinitely variable. We add the sociologist's dictum that personality is the individual's peculiar embodiment of the ideas and customs of the culture to which he belongs. We cap it with the psychiatrist's finding that through all the flux of behavior and feeling there is consistency and that there are depths to the personality of which the conscious mind is not aware. . .

We mean by personality the thinking, feeling, acting human being, who, for the most part, conceives of himself as an individual separate from other individuals and objects. This human being does not *have* a personality; he *is* a personality.

KNOWLEDGE ABOUT PERSONALITY

For knowledge about personality there is no one source of information. . . . We cannot wait . . . for complete knowledge or wholly developed theory, if only because there is no such eventuality in science. . . Nor can we rely wholly upon science for ideas about how to help children develop in a healthy manner. The insight and intuition of wise practitioners in all professions add much to the knowledge that we may act upon.

COURSE OF DEVELOPMENT

In each stage of child development . . . there is a central problem that has to be solved, temporarily at least, if the child is to proceed with vigor and confidence to the next stage. . . . Each type of conflict appears in its purest, most unequivocal form at a particular stage of child development. . . . If the problem is well solved at that time the basis for progress to the next stage is well laid.

Sense of trust

. . . First to develop is the sense of trust. The crucial time for its emergence is the first year of life. . . . A sense of trust cannot develop until the infant is old enough to be aware of objects and persons and to have some feeling that he is a separate individual. . . .

Experiences connected with feeding are a prime source for the development of trust. . . . Later experiences, starting at around 5 months of age, add another dimension to the sense of trust. Through endless repetitions of attempts to grasp for and hold objects, the baby . . . is gradually able to trust his own body to do his bidding. . . . As their own bodies come to be more dependable, there is added to the pleasures of increasing sensory response and motor control the pleasure of the mother's encouragement.

For most infants . . . a sense of trust is not difficult to come by. It

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Excerpted from "For Every Child a Healthy Personality; a Digest of the Fact-finding Report to the Midcentury White House Conference on Children and Youth" (copyrighted by the Midcentury White House Conference on Children and Youth, Inc., Washington, 1950. 54 pp). These excerpts are all from part 1, "The Making of a Healthy Personality"; part 2 is entitled "Implications for the Conduct of Social Institutions." The larger report of the Technical Committee on Fact Finding will be published privately in a few months.

s the most important element in the personality. It emerges at the most vulnerable period of a child's life. Yet it is the least likely to suffer harm, perhaps because both nature and culture work toward making mothers most maternal at that time.

Sense of autonomy

The sense of trust once firmly established, the struggle for the next component of the healthy personality begins. The child is now 12 to 15 months old. Much of [the child's] energy for the next 2 years will center around asserting that he is a human being with a mind and will of his own. . . . For a child to develop this sense of self-reliance and adequacy . . . it is necessary that he experience over and over again that he is a person who is permitted to make choices. . . . At the same time he must learn some of the boundaries of self-determination. . . .

Those who would guide the growing child wisely . . . will avoid shaming him and avoid causing him to doubt that he is a person of worth. They will be firm and tolerant with him so that he can rejoice in being a person of independence and can grant independence to others. . . .

Parents' ability to grant children the kind of autonomy Americans think desirable depends in part on the way they are treated as employees and citizens. . . . Much of the shame and doubt aroused in children result from the indignity and uncertainty that are an expression of parents' frustrations in love and work.

Sense of initiative

. . . The child of 4 or 5 wants to find out what kind of person he can be. To be any particular kind of person, he sees clearly, involves being able to do particular kinds of things. So he observes with keen attention what all manner of interesting adults do, . . . tries to imitate their behavior, and yearns for a share in their activities. . . .

Feeding experiences are a prime source for the development of the baby's sense of trust.

By this age, too, conscience has developed. The child is no longer guided only by outsiders; there is installed within him a voice that comments on his deeds, and warns and threatens. . . . Children now begin to feel guilty for mere thoughts, for deeds that have been imagined but never executed. . . .

At no time in life is the individual more ready to learn avidly and quickly, to become big in the sense of sharing obligation and performance. . . . The sense of initiative . . . is one that must be continually fostered, and great care must be taken that youngsters and young people do not have to feel guilty for having dared to dream.

Sense of accomplishment

The fourth stage, which begins somewhere around 6 years of age extends over 5 or 6 years. . . . This is the period in which preoccupation with fantasy subsides, and the child wants to be engaged in real tasks that he can carry through to completion. . . It is during this period that children acquire not only knowledge and skills that make for good workmanship but also the ability to cooperate and play fair and otherwise follow the rules of the larger social game. . .

The chief danger of this period is the presence of conditions that may lead to the development of a sense of inadequacy and inferiority. . . . It is most important for health of personality . . . that schools be conducted well, that methods and courses of instruction be such as will give every child the feeling of successful accomplishment. . . It is upon teachers that the professional responsibility for helping all children achieve a sense of industry and accomplishments rests. . .

Teachers cannot work alone, of course, either in aiding a child in the development of new capacities or in strengthening old ones. Jointly with parents and others they can do much, not only for children of already healthy personality but also for many whose development has been handicapped.

Sense of identity

With the onset of adolescence another period of personality development begins. . . The central problem of the period is the establishment of a sense of identity. The identity the adolescent seeks to clarify is who he is, what his role in society is to be. Is he a child or is he an adult? Does he have it in him to be someday a husband and father? What is he to be as a worker and an earner of money? Can he feel self-confident in spite of the fact that his race or religion or national background makes him a person some people look down upon? Over all, will he be a success or a failure?

By reason of these questions adolescents are sometimes morbidly preoccupied with how they appear in the eyes of others as compared with their own conception of themselves, and with how they can make the roles and skills learned earlier jibe with what is currently in style. . .

The danger of this developmental period is self-diffusion. . . A boy or girl can scarcely help feeling somewhat diffuse when the body changes in size and shape so rapidly, when genital maturity floods body and imagination with forbidden desires, when adult life lies ahead with such a diversity of conflicting possibilities and choices. . .

Hard though it be to achieve, the sense of identity is the individual's only safeguard against the lawlessness of his biological drives and the authority of an overweening conscience.

Sense of intimacy

. . . Boys and girls late in adolescence usually have need for a kind of fusion with the essence of other people and for a communion with their own inner resources. If, by reason of inadequacies in previous personality development, this sense of intimacy cannot be achieved, the youth may retire into psychological isolation and keep his relations with people on a formal, stereotyped level that is lacking in spontaneity and warmth or he may keep trying again and again to get close to others, only to meet with repeated failure. Under this compulsion he may even marry, but the role of mate is one he can rarely sustain, for the condition of true twoness is that each individual must first become himself. . .

. . . American adolescents are likely to be unsupported by their parents and to find little confirmation in story or song for their desire to sense intimately the full flavor of the personality of others. In many of them, then, the sense of intimacy does not develop highly and they have difficulty in finding in close personal relations the outlet for tension that they need. . .

Parental sense

. . . The individual has normally come to adulthood before the parental sense can develop fully. . . . The essential element is the desire to nourish and nurture what has been produced. It is the ability to regard one's children as a trust of the community, rather than as extensions of one's own personality or merely as beings that one happens to live with. . .

. . . In order that most people may develop fully the sense of being a parent, the role of parent, both mother and father, must be a respected one in the society. Giving must rank higher than getting, and loving than being loved. The economy must be such that the future can be depended upon and each person can feel assured that he has a meaningful and respected part to play. . . .

Sense of integrity

. . . In every culture the dominant ideals, honor, courage, faith, purity, grace, fairness, self-discipline, become at this stage the core of the healthy personality's integration. . .

. . . Integrity . . . means a new and different love of one's parents, free of the wish that they should have been different, and an acceptance of the fact that one's life is one's own responsibility. It is a sense of comradeship with men and women of distant times and of different pursuits, who have created orders and objects and sayings conveying human dignity and love. . . . The possessor of integrity is ready to defend the dignity of his own life style against all physical and economic threats. For he knows that, for him, all human dignity stands or falls with the one style of integrity of which he partakes. . . .

In considering healthy personality development we must take into account the fact that each child has his own individual pattern, and that his nature cannot be arbitrarily shaped.

. . . Not only parents but all who eal with children have need of this uality if they are to help children aintain the feeling that the uni-erse is dependable and trustworthy.

INFLUENCE OF CONGENITAL CHARACTERISTICS

. . . Fifty years or so ago constiutional factors were believed to be f prime importance, and developent was thought to be largely a atter of their maturing. Children, n other words, were regarded as iniature editions of the adults they ere to become. . . Within the last uarter century an almost complete hange-about of scientific thought ook place. Environment became he clue to almost all differences in uman functioning. . . At present cientific opinion stands somewhere etween the two extremes. . . Each hild's congenitally given charac-eristics will determine to some extent not only how he deals with the problem but also whether he finds dealing with it easy or difficult. . .

Congenital differences can be seen most clearly in newborn and young babies, and it is largely such differences that will be described below.

Differences in activity and vigor.—Some [babies] will rarely be altogether quiet, and some will seldom move other than delicately. After a few weeks the active ones will kick and wriggle with excitement when spoken to, while the others will respond to stimulation with a still, absorbed kind of wonderment.

. . . All [research workers] agree . . . that very active children and very placid children must be treated differently by their parents and others if they are to develop optimally.

Differences in sensitivity.—. . . The world is a very different place for a sensitive infant from what it is for an imperturbable one. The sensitive child is so flooded with perceptual stimulations that he may easily become fatigued and irritable. The imperturbable one does not notice the lesser lights and sounds and so may find adjustment easier. Both kinds of infants can develop perfectly normally if properly cared for, but just because of their constitutional make-up their needs are different.

Differences in tempo and rhythm. . . . Infants who eat and digest slowly are very likely to do other things slowly too. If this is so and if the tempo differences of infancy carry over into later life, it is clear that child-rearing practices must take this into account if slow children are not to feel frustrated by excessive demands for speed.

Differences in reactions.—Many infants have characteristic bodily reactions to a great variety of disturbing factors.

. . . In response to an inoculation, a cold, a sudden change in routine, some babies develop a fever, others a digestive disturbance, others a skin irritation; and some respond by disturbances in eating or sleeping. . . The significance of these well-established differences for personality development is only beginning to be studied. . .

Differences in intellectual endowment. — That children differ in amount of intellectual ability is well known. Less widely understood is the fact that they differ also in kind of intelligence, and that the extent to which they are able to make use of whatever kind and degree of intelligence they possess depends upon both social and psychological factors. . .

Differences in speed and rhythm of growth.—. . . There is individual patterning in children's development and . . . human nature cannot be arbitrarily shaped and formed. . . . We must not expect children to live up to set standards of behavior and progress.

Effect on sense of trust

. . . We have good reason to believe . . . that a very sensitive infant must be handled somewhat differently from other babies. For instance, he should be protected from overstimulation. Instead of being played with actively and exposed to numerous sights and sounds (experiences that give pleasure to the more robust baby and so increase his sense of trust) the very sensitive infant should be handled gently, and only slowly introduced to new experiences. Treated thus, he will be just as likely as his more robust brothers to arrive at a firm sense of trust.

Effect on sense of autonomy

. . . Very active children and those who are unusually inactive are likely to find this developmental phase unusually difficult. The first must be patiently helped to realize and accept necessary limitations. The second must be encouraged to act on their own. . . .

Effect on sense of initiative

. . . Children who develop rapidly in bodily size and manual dexterity are likely to feel competent in whatever they undertake. . . Such children, rather than benefiting from success, may find it increasingly difficult to accept that they are only young children, after all.

Children who develop slowly . . . require more than average help to resolve the conflict between wanting to be powerful and resourceful and feeling futile and guilty about the attempt. . .

Effect on later stages

. . . Because they are congenitally different . . . because they just are not made alike, children must not be expected to behave identically, and methods of training and education must take this fact into account.

PHYSICAL CONDITIONS AND PERSONALITY

There are . . . . so many ways in which physical disabilities and chronic illnesses are alike in their hazards for personality growth that specialists are inclined to stress the similarities instead of the differences. . . Some parents will be oversolicitous, adding to the children's difficulties by their babying. Others will try to force the child beyond his capacities and so add to his feeling of inferiority. Some will feel so personally inferior at having a physically disabled child that they will push him aside or treat him coldly. . .

. . . If the disabling condition

develops after early childhood, it is likely to affect the child's feeling about himself. . [It] may contribute to all the negative aspects of personality development; to mistrust, self-doubt, feelings of inferiority, and the rest.

THE INFLUENCE OF PARENT-CHILD RELATIONS

. . . It is difficult to state the facts without making parents feel that they are to blame for all inadequacies in their children's development. . . . We hope to show that "blame" is not the word for it. If parents can be relieved, in some measure, of feelings of anxiety and guilt in this connection, they will probably have more energy and intelligence to give to meeting the real challenge of the job of bringing up children. . .

Studies indicate that parents' attitudes toward children and their feelings about them are more important determinants of children's health of personality than the particular techniques of child-rearing they employ. . . . It is the over-all emotional tone of the home that counts for most, and . . . the specific techniques are valuable chiefly when employed by parents who can carry them out with confidence and with genuine concern for the child's well-being. . .

. . . What is often overlooked is that nearly all parents, even the most "rejecting," have affection for their children. . . Child-guidance workers find that even those parents and children who are most embroiled in expressing hostility are likely to have love for each other that is hidden under their anger.

. . . Money worries, marital difficulties, resentment about the way they are treated at work or in other social relations, inadequate preparation for parenthood, uncertainty about one's role as a parent; these and numerous other factors may interfere with the free expression of parental love. . . .

. . . Parents need not only love for their children but also confidence in their ability to rear them wisely if they are to do a good job. For the latter they need society's backing. . .

ECONOMIC FACTORS AFFECTING PERSONALITY

. . . Health of personality in adulthood requires that the person feel that he is a person that matters and that life has dignity and meaning. If economic arrangements d not sustain these beliefs, children' personality development is likely t suffer. . .

. . . It is clear that economi status operates both directly an indirectly to affect health of pe sonality. Its influence is so closel tied up with cultural and psych logical factors that exact measur of its importance is impossibl Nevertheless, it seems clear tha much attention must be paid to by those who seek to assure tha children grow up to be happy an responsible citizens. . .

. . . Studies are almost unan mous in showing that children fro low-income families are more likel to be maladjusted than those whos parents have more money. . .

It is the cultural differences tha are associated with extremely lo incomes and the reaction of th middle-class part of the communit to them that especially handica the children of the "lower-lower class in personality development.

In school and in the community children and youth of the "lowe lower" class are usually discriminated against by agemates an teachers and are made to feel tha they do not belong. . . For a adolescent to admit that he is on of the despised in a society tha maintains that all are of equa worth is most difficult. No wonder, then, that many such youth early escape from the unpleasan situation and band together in gang that defy middle-class values. .

. . . One of the chief question that arises is whether a more nearl equal distribution of income woul tend to break down such social class structure as at present exist or, at least, make the difference among classes less hazardous t health of personality.

THE EFFECTS OF PREJUDICE AND DISCRIMINATIO

. . . It is unquestionable that in many respects and to a greate or less degree, Negroes, Jews, Latin Americans, Orientals, Southern an Eastern Europeans, Indians, mi grants, and so on are regarded a

If parents are to do a good job they need not only love for their children, but confidence in their ability to rear them. And for the latter they need the backing of society.

Not only parents but all who deal with children need to have a strong sense of integrity if they are to help children feel that the universe is dependable and trustworthy.

socially inferior and are discriminated against. . .

. . . This is not to say, of course, that all who are discriminated against are doomed to poor health of personality. What is meant is that discrimination and prejudice put obstacles in the way of healthy development and make the full utilization of potentialities more difficult. . .

. . . Sudden exposure to the fact that one is not considered as good as other people is very disrupting to personality development. It is a shock to the sense of trust, an incitement to feelings of doubt and shame. . . .

For children who grow up in the perhaps more common situation of being daily exposed to the fact of their difference the consequences may be more serious, since their early personality development is likely to be disturbed. . . .

Feelings of inferiority growing out of an inability to achieve success in the kind of tasks that are commonly set in school are likely to characterize children whose homes do not prepare them for intellectual efforts. Some minority-group children are especially handicapped in this way. . .

For these children who so frequently have been confronted with prejudice and discrimination, adolescence is a particularly trying period. In addition to their own inner confusion they must bear with the dominant group's own insecurities, which so often take the form of cliquish antagonism. . . . That some should band together in delinquent gangs and others take refuge in neurosis is not surprising. The majority pull through somehow or other but nobody knows with what burden of resentment and bitterness.

RELIGION AS AN AID TO HEALTHY PERSONALITY

For the development of a sense of integrity, the culminating component of the healthy personality, it has been said that the individual must have some conception of the universe as meaningful and benevolent and of his place in it. He must integrate his life around some ethical or religious concepts. Honor, grace, faith, courage—some integrating idea or ideal—must replace his parents as the objects of dependency and trust. Having such a core of security in his inner being, the mature adult can transmit a sense of trust to his children and thus start them on the way to emotional well being. . .

. . . It has been shown throughout our analysis that children's well-being is dependent in large part upon their parents' sense of self-worth and that that sense is intimately related to the values and workings of the society in which they live. The ethical and moral affirmations of religion constitute the base on which all this rests and from which social malfunctioning can be criticized. . .

. . . It is the view of religion that man need not reject any part, aspect, or facet of himself but should accept the self in its totality as part of the plan of God for his creation. Thus the sexual impulses, which are central in so many personality disorders, are to be recognized as a fact in human life. . .

Healthy self-acceptance requires also a realistic view of one's self. Every individual has some sort of picture of what he is and what he would like to be. As he strives to fulfill his self-ideal, defeat shows him that there are lines of development that for him are impossible. If he cannot accept this fact, he is likely to develop unrealistic and self-defeating compensations or, failing that, to have a mental breakdown. Religion helps here by urging humility and by stressing the universality of God's love. . .

. . . There is evidence in the case records of psychotherapists that injury may be done to personality by overemphasis on wrongdoing and underemphasis on faith in the individual's potentialities for goodness.

In calling people to be "children of God in the midst of a crooked and perverse generation," to love their neighbors without regard to race or creed or accidental circumstances, to do the will of God in a society that ignores or denies that will, religion provides integrating ideals of the highest order. For the mature adult, as well as for the adolescent, those ideals are an inspiration and a challenge. . .

MOBILIZING CITIZENS FOR ACTION—STATE AND LOCAL

State and local committees of the Midcentury White House Conference are planning to continue their work, staying together to follow up the conference recommendations.

THE evidence is overwhelming that the American people want the best for their children and that they are deeply concerned when they find inadequate, questionable, or harmful practices and services in any community. Leadership in these studies has emerged not only from traditional sources such as parent-teacher associations, but from what appeared unlikely sources—the butcher, the baker, the candlestick maker, the rich man, and the poor man. An amazing variety of people have contributed to the program for children as it has developed this year in communities in every State and territory.

We shall agree on our general direction

Some of the problems unfolded are as old as the community itself and have often been reported and discussed. The important gain here is not in terms of new information, new definition of problems, or solutions, but in the significant number and variety of individuals and agencies that have been working together to pool their information, look at the situation from a fresh point of view, and agree to do something. The facts have begun to filter through the mind and the conscience of individuals and communities. They express a resolve to find a bargaining place, something within immediate reach, and agree on the general direction they should take to get started without waiting until everybody agrees upon everything.

They also admit that they can't do it all at once and may have to put aside for later consideration some of the problems which at the moment appear too overwhelming, too costly, or perhaps not now quite clear enough to work on. They see the challenge as twofold: immediate goals, no matter how small or how segmental they may seem, so long as they are directed toward increased understanding or improvements of conditions for children; (2) long-range goals, many of which have already been formulated, others that will require further research, discussion, and clarification.

"Something is within reach," these State committees say, and they indicate an awareness of the channels through which improvement in conditions and services for children should be expected in the immediate future and in the decade ahead. They suggest that many of the findings have important implications for

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Excerpted from "Citizens in Action; Report on State and Local Action to the Midcentury White House Conference on Children and Youth." (Washington, 1950. 61 pp.) Copies of this report may be purchased at 75 cents each from the Midcentury White House Conference on Children and Youth, Washington 25, D. C.

the individual. They see how the facts have come home to persons and how persons have responded to them. They point out what an individual might do in such interrelated capacities as parent, voter, neighbor; as an informed and fair-minded person—volunteer, staff member, church member, public official, taxpayer, and contributor. They quote the many who have said, "Maybe somebody already knew most of these things, but I didn't"; or, "Maybe this has been said in many places and upon many occasions, but this is the first time I understood what they were talking about." It seems that the facts have, many of them, hit home during this year of intensive citizen activity, and that the individuals who have gained new information and new insight are ready to start "to do something." They are ready to start with themselves. "I've just begun to catch on to this focus," they say, "and there's a lot more I need to listen to and read and talk about, but if this keeps up my kids will have a better chance than I had."

What happens after the conference?

These individuals, however, see that the gains they are aware of are a direct result of State and local organization and did not just happen. They want the process to continue and deepen and take in more territory after the conference. They want to know what is reported and recommended in December and how they fit into the larger plan. In talking about the tradition of the White House Conferences for Children they point out that each generation has contributed its interpretation and clarified its concerns and goals for children; that each conference has made progress and resulted in better understanding of children and their problems, in improved and expanded services, in legislation, court decisions, agency practices, and an enlightened citizenry. "But," they say, "this time we want to hold our committee together to follow through." They add, "it seems to us that we've just barely gotten started — the real work is just beginning. We know some of the things we ought to do but we still have to do them before it does the children any good."

Essentially the State reports convey that it is important to grasp the opportunity offered by the present interest. The impact of the amazing year 1950 must not be lost or dissipated for want of a practical program in which citizens can continue the work. They are agreed that without concrete, practical plans for responsible committee leadership after the conference neither the State and local recommendations nor the national recommendations can be made effective. The follow-up program is seen as one of the most important phases of this fifth White House Conference. The fact-finding and discussion program of the conference preparation period becomes the stimulus for the continuing program for community and Nation-wide improvement. One report reflects the story in many reports, "In county after county and in community after community we have already seen citizens who have participated in the county fact-finding committees move forward into realistic action programs long before the ink has dried on the county and State report."

The need for a follow-up program has been discussed in each State. The question which many have answered to their own satisfaction but which other committees are still debating is "What is the best machinery through which this planning can be accomplished in our State?" . . .

Approximately a third of the counties in the Nation have had committee activity this year. About a dozen States have depended upon regional organization. Nevada, with widely scattered population, organized by towns of over 200 and had a committee and a town meeting in each of its 22 towns and cities. Alaska organized in towns as small as 50. States with large metropolitan areas have often found these hardest to organize for "grass roots" participation. A large item of unfinished business is to find ways of bringing the enterprise home to the large urban community which tends to count on its agencies and paid workers. In the crowded city a citizen often knows only the small unit of the city where he lives or the segment in which he works. The smaller places responded immediately to the flavor of State and local action, the neighborly invitation to join forces and talk things over.

Large or small, urban or crossroad, each community still faces the need to think further about the whole child and his total needs, and to enlist the interest of all the people whose lives touch his in any way, directly or indirectly. . . .

For a continuous program

In discussing the work to be done in the next few months and in the years immediately ahead, the committees express the hope that some provision will be made for coordination of their efforts with those of other State committees, national agencies, and all Federal and State agencies serving children. They want the stimulus of a national as well as a local emphasis, and some provision for national guidance. They want materials which will expand their immediate horizon and concerns and which will keep them abreast of wider issues and of solutions found elsewhere. They hope to go on getting together as an advisory council on State and local action, and to meet with four or five States at a time to talk things over and trade ideas. They ask for more help from the national agencies, more suggestions on how to plan for children on a broader base and more soundly. They want further exploration of the focus, more help in discovering the whole child. They offer their full cooperation and their sustained support in any plan that provides for a continuing program for the Nation's children.

As one farmer on a committee put it, "We have done a fine job of planting ideas and interest all over the State. Now I want to help cultivate every field and even more I want to be on hand as we harvest the crop."

YOUTH SPEAKS UP

ADULTHOOD is not determined by age but by the degree of maturity the individual has attained. Because an adult is the combination of idealism and realism, the idealism of youth may be reinforced with the realism of adults.

Maturity begins when one takes his first responsibility. In proving we can take responsibility, we will then be given more opportunity to further demonstrate our ability. As we grow older, our obligations grow also. Adolescent responsibilities become adult responsibilities. Many of the youth of today are called upon to grow up faster than previous generations.

In the opinion of youth, some adults act as if the young people are going to stay young. Many adults treat youth as if they will always remain rash, incompetent, uninterested, and selfish. If we are made to feel incompetent, we may soon believe that we possess no capabilities.

In general, adults may expect too little from youth. Youth can do many things which will prove their value to society. The mature young person is always looking for a chance to improve himself and his environment.

Times have changed

Present-day youth has more chance for education, social activities, and general experience than the last generation. Therefore, we should be better qualified to tackle problems than our fathers were when they were young. We have at our disposal more practical knowledge, more modern equipment, and an increased mutual understanding to enable us to face many problems.

Usually as we enter high school, we begin to take on adult responsibilities. At that time we are expected to choose a course or vocation which will be a major part of our adult life. At this age, however, we are often in doubt as to what we want to do in the future. We want and need guidance of understanding adults, as we seldom know the problems of selecting a career.

We believe that we should be permitted to grow at our own pace, but not alone. When we have the opportunity to work with adults and gain confidence, we have a better chance to grow into maturity easily and gracefully. Some relatives and friends often ridicule a young person because he does not meet their own set of standards. Some expect youth to finish school at a certain age or have a job or marry at the age they think proper. They overlook the fact that because youth must set his own pace, he should not be subject to ridicule. But others realize the difficulties and fears of growing up and try to prepare us for it.

Although we must be prepared to step into an adult role, it must be by a gradual process. In school, for example, voting to elect student officers is a real responsibility and it teaches us the seriousness of voting as citizens.

In growing up we spend many hours thinking about the kind of adult we want to become. Adults we know influence us by the examples they set. If we have never known our parents to vote, if they try to be relieved of jury duty or always grumble about high taxes, they do not help us learn good citizenship. We must be better prepared than the adults of today to be leaders, since the main goal in life is to pick up where our fathers left off and make a better world.

Only in recent years have we been able to speak our minds to adults. In the past, we could not tell adults in the family or in organizations that they were interfering too much or even tell them about problems. This condition has changed a great deal, but not enough. What we seek is neither control by, nor independence from, adults. We want the kind of sup-

Our young people of the present time understand that they have responsibilities as citizens.

Young members of an adult-sponsored organization need to feel that they really belong to it. And in order to have this feeling they need to share in managing the program.

port from adults that backs us up and yet gives us freedom to move ahead independently to the extent that we can.

Youth and the Nation

The youth of today are growing into a world that needs mutual understanding and cooperation of all peoples to survive. This calls for improved intergroup relations across social, economic, religious, racial, and nationality lines. When all youth cannot develop on a free and equal basis, the Nation suffers in its leadership, development of resources, and quality of citizenship.

Although parents must recognize the right of children to think for themselves, they need by example and teaching to impress upon young people the fundamental principle of valuing and respecting the individual person for his ability and accomplishments rather than because of his race, creed, or national origin. Part of this, too, is the importance of helping young people to understand and accept differences within the family and the community, and among people.

Education should be available to all young people according to their need and their ability. The fundamental principle of respect for the individual on the basis of his ability or accomplishments must be supplemented and reinforced by the school through its philosophy of teaching and actual practice. The school curriculum should give pupils knowledge of the contributions of the many groups, each with a different economic, social, and religious background, which make up America. Classroom relations should include the right of the pupil to examine the facts, to disagree and express his opinion, and to form his own conclusions. Student governments should be developed to give young people the chance to learn how to be members of a group and to assume responsibilities of a public office.

Since respect for the individual is common to all religious faiths, and since the right to worship as one's conscience dictates is basic to American democracy; to improve intergroup relations it is essential that all people respect the right of others to worship and to believe as they please.

All youth organizations or adult-sponsored groups serving youth and supported by the general public have the obligation to accept all individuals into full and equal participation on the basis of their interests rather than accepting some as members and restricting others to being merely contributors and onlookers. Youth members in adult-sponsored youth organizations must have a share in the planning and management of the organization. This is essential if young people are to have a real sense of belonging, and are to make their most significant contribution to the work of the organization.

Youth accepts responsibility for developing a community where all citizens, regardless of race, creed, or social or economic status, are entitled to share in the benefits, rights, privileges, and obligations of citizenship.

We look toward 1960

Each person should have the opportunity to advance economically according to his natural capabilities and without limitations of race, creed, or national origin. Improved intergroup relations between employer and employee call for recognition of their mutual interdependence, exchange of ideas, cooperation, and observance of the dignity of all labor.

The day has passed when we can be concerned with ourselves only. What we want for ourselves, we want for all people. We recognize our responsibilities as good citizens. These are the goals we have set for ourselves as young people to achieve in cooperation with adults. Ten years hence, at the 1960 White House Conference on Children and Youth, we expect to review them as adults.

Excerpted from "Each is of Infinite Worth; Statement by the Advisory Council on Youth Participation." This is the first report in a bulletin combining three reports on conference participation—by youth, by national organizations, and by the Federal Government. (Washington, 1950. 122 pp.) Copies of this bulletin may be purchased at 75 cents each from the Midcentury White House Conference on Children and Youth, Washington 25, D. C.

MOBILIZING CITIZENS—NATIONAL ORGANIZATIONS

THE STATED objectives of the national organizations in the fields of health, education, welfare, youth services, religion, and the general community are closely related to what they believe to be the needs of children and youth and of our democratic society. One is impressed by the all-inclusive character of their collective goals and by the wide variety of their specific aims.

In every group of national organizations there is one common objective: To secure and provide more effective coordination and extension of services at all levels. Health agencies work toward the exchange of current information and the interpretation of their professions to related groups and agencies. Educators stress the importance of wider interchange of ideas and of closer working relations between schools and other community institutions. The majority of welfare organizations emphasize the value of planning for and by the community as a whole and the need for stimulating action to obtain well-rounded and integrated services.

Resources pooled

Many groups have as a goal providing general information and clearinghouse services for all agencies serving children in a given field. Some organizations focus on the development of close working relationships between home and school, while others stress the importance of discussion in solving common problems. Still others seek to pool the resources and skills of education, health, social work, and recreation.

Frequently given as a major purpose is the closer coordination of all services for children at the National, State, and local levels. A similar unanimity is found in the desire to educate the public toward a greater awareness and deeper understanding of the needs of children and youth, as well as toward wider acceptance of the goals and the programs of the national organizations themselves.

Health groups try to disseminate information on health problems more widely to the general public. They also wish to educate society so that it will more readily receive and accept handicapped children on their own merits as individuals, and accordingly will be prepared to provide them with as normal a life as possible. Educational organizations work toward producing attitudes among citizens which will lead them to give more thought, devotion, and money for the better education of all children. The majority of groups in the fields of welfare and the general community, and those with youth memberships, carry on continuous efforts to create an informed and awakened public which will accept and support their programs.

The maintaining of high standards is frequently mentioned as a major purpose. One goal of the health agencies is to provide a better quality of service to the public. Welfare groups work for more effective operation of organizations on National, State, and local levels. In education, stress is laid on the strengthening of the status of the profession of teaching, through high standards of performance, and through study and improvement of professional practices. One of the goals of educational organizations is to maintain the right of the teacher to present all points of view without hindrance, as fundamental to preserving the integrity of education in a free society. Almost every group mentions the importance of more highly qualified and trained personnel. Some set professional standards, while others try to improve the quality of leadership through more adequate preliminary and in-service training.

The provision of indirect services to children and youth is the goal of many groups. Some act in an advisory capacity, offering consultation to families and to other groups and agencies in the same general sphere of interest. Religious organizations render this type of service to agencies of the church; to orphanages, settlements, children's homes, and schools. Community groups, through investigation, study, and research, try to learn more about the conditions that lead to delinquency. Others have as their purpose the enactment of more effective Federal and State legislation for the care and protection of young people. Some organizations emphasize the importance of determining needs and of taking action, noting the trends of congressional thinking and trying to influence it directly. More adequate legislation and enforcement in the broad areas that relate to employment are of special concern, in order to safeguard young people from exploitation, and from conditions detrimental to their best development.

Educational groups seek to improve the environment, health, and educational growth of children and youth. Welfare agencies promote slum clearance, social security, and housing projects. Like the commu-

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Excerpted from "For the Nation's Children and Youth; Report by National Organizations on Programs and Services." This is the second report in a bulletin combining three reports on conference participation—by youth, by national organizations, and by the Federal Government. (Washington, 1950. 122 pp.) Copies of the bulletin may be purchased at 75 cents each from the Midcentury White House Conference on Children and Youth, Washington 25, D. C.

nity organizations, they work for higher standards of living for the family, city, State, and Nation. Youth-membership groups include among their objectives the improvement of the environment, with more health-education and recreation facilities at every level, and with wider opportunities for constructive use of leisure time at home, in school, and in the community. Some community organizations work to raise the standards and quality of entertainment in the theatre, radio, movies, and television. Others follow the major purposes of fostering of conditions that facilitate effective guidance, and of providing more adequate counseling services at every level, with special emphasis on vocational and employment counseling for young people entering work.

The specific objectives in terms of direct services are widely varied. Welfare groups seek to supply adequate social, religious, and recreational programs. Youth-membership organizations stress the importance of giving young people opportunities to gain a sense of belonging and fellowship within a group or a movement which may be Nation-wide and, in some cases, international in scope. Religious organizations have as a major purpose the bringing of children and young people into proper relationship with God and their fellow men, and the development of a sound religious experience in youth. Community and welfare organizations, as well as those with youth memberships, work to strengthen and to improve the quality of family life. Some organizations stress the need of preparing young people for special vocations and professions. Many provide programs which will give children opportunities for creative expression, through developing their special interests and abilities. A further goal is to supply satisfying group experiences as a means of encouraging sound social adjustment.

The reports stress as a common aim the fullest development and use of all the potentialities of children and youth. Health groups protect well children and prevent ill health wherever possible. Welfare and community organizations attempt to prevent delinquency through home, school, and community activities. Educational groups work toward the development of the whole personality, while community and youth-membership organizations try to strengthen certain virtues: Patriotism, courage, self-reliance, and the capacity for constructive leadership.

To meet special needs of children

Although it is recognized that all children have the same basic needs, the purpose of many national organizations is to meet the special needs of certain children. Health groups work to prepare handicapped children to assume a role in society commensurate with their capacities. Educational groups are concerned with the solution of problems presented by the gifted, as well as by those with physical, mental, or emotional handicaps. Welfare organizations give convalescent care to the sick and the handicapped and provide help for children in special difficulties. They seek to rehabilitate delinquents through education, vocational guidance, and better health. Some community organizations have as their goal the raising of the standards of moral, material, and spiritual living of children in such minority groups as migrants, sharecroppers, and Indians. Many try to direct attention to the special needs of rural youth, helping local groups to find and use resources for better service.

It is significant that most of the national organizations claim as a major purpose the development of social responsibility and of the democratic way of life among children and youth. Youth-membership groups offer training programs in citizenship and community affairs, with experience in social living and creative leadership to further the practice of serving the school, the community, the State, the Nation, and the world. Educational, welfare, religious, and community organizations express their concern for the encouragement of democratic ideals and the strengthening of the democratic patterns of society. Through sponsorship of programs involving young people of different racial, religious, and cultural backgrounds, they work to instill the ideal of the brotherhood of man and the dignity and worth of every individual.

Some national organizations offer children such programs as camping, in an effort to provide them with satisfying group experiences as a step toward sound social adjustment.

OUR FEDERAL GOVERNMENT IN THE SERVICE OF CHILDREN

THE FEDERAL GOVERNMENT has become increasingly involved in programs for children and youth as recognition has grown that its participation is necessary in the development of Nation-wide services for this one-third of the Nation's population that represents the future.

Under the obligation of the Federal Government to promote the general welfare of the people of the United States, the Congress has enacted laws establishing Federal agencies and authorizing activities designed to contribute to the well-being of people. Part of the activities authorized are directed especially toward benefiting children and youth.

A review of all the Federal programs serving or affecting children and youth brings to light the wide variety in types of programs in which the Federal Government participates and the great numbers of children and youth benefited. In general, these activities parallel the programs undertaken by communities because essentially they supplement such programs.

The concern of the Federal Government for the health of children and youth begins with the prenatal period. It includes the promotion of environmental sanitation, the protection of the food and water supply, the prevention and control of disease, and the safeguarding of the sound growth and development of children.

Children and youth in many families benefit from programs that the Federal Government takes part in, but no such program is extensive enough to reach all who need the services.

The Federal Government conducts research on the growth and development of children, the prevention and treatment of illness, food values and nutrition, clothing, and home management. Information based on research is made available to parents and others. It assists in financing maternal and child health services, care of crippled children, school lunches, and public health services for the protection and promotion of community health. It contributes to the construction of hospitals and health centers. It regulates the quality of food and drugs permitted to move in interstate commerce.

Early in its history, the Federal Government gave public lands to the States for the support of the common schools, colleges, and universities. It shares in the research essential to the development of education and gives advisory service on elementary, secondary, and higher education, and on parent education and other phases of adult education affecting children and youth. It provides financial assistance for educational programs such as vocational education, college education in agriculture and the mechanic arts, and extension work in agriculture and home economics, and it contributes toward the professional education of workers needed under certain State and local programs in which the Federal Government participates. It has assumed direct responsibility for the education of special groups, including the education of American Indian children, a school and

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Excerpted from "How the Federal Government Serves Youth; Statement of the Advisory Council on Federal Government Participation." This is the third report in a bulletin combining three reports on conference participation—by youth, by national organizations, and by the Federal Government. (Washington, 1950. 122 pp.) Copies of this bulletin may be purchased at 75 cents each from the Midcentury White House Conference on Children and Youth, Washington 25, D. C.

college for the deaf, a university serving Negroes primarily, and training for the armed forces, the Coast Guard, and the merchant marine. It provides educational materials for blind children. It provides advisory service on the development of apprentice training.

In the field of recreation, the principal contribution of the Federal Government consists of recreational facilities in the national parks and forests and on other public lands. Certain Federal agencies provide advisory service on recreation for children and youth in connection with their programs. Educational programs conducted by the Federal Government also include recreational opportunities.

Social service to help meet the individual problems of children and youth is an integral part of many of the programs in which the Federal Government participates. Social service forms a part of the service to American Indian children. The Federal courts have social workers to investigate the background of youth brought before the courts and to supervise those placed on probation and released on parole. The personnel services program of the armed forces includes service to young men in service and advice to personnel with dependent children on the rights and benefits, and opportunities available for children and youth.

Research is conducted and consultation service is given on the problems and the means of dealing with the problems of children and youth who are handicapped physically, emotionally, or socially and on the legal measures needed for their protection. Financial aid is given to the States to aid in developing State and local child-welfare services. Medical social service is included in programs relating to medical care. Social service is an integral part of the administration of grants for public-assistance programs, including aid to dependent children.

Another part of the Federal Government's share in social-welfare programs is its contributions toward the support of children. Federal laws authorizing monetary benefits for veterans and their dependents provide compensation for the children of veterans whose death is service-connected, and pensions for the children of deceased war veterans when the death is not service-connected. Additional allowances for children are also payable to certain veterans suffering from service-connected disabilities. Funds are provided for assistance in the support of dependent and neglected American Indian children or for their care in boarding schools. Federal grants are made to the States for aid to dependent children to make possible their being brought up in their own homes or in the homes of relatives. The Old Age and Survivors Insurance system and the retirement system for railroad workers established and administered by the Federal Government are providing monthly benefits for children of deceased insured workers and for the widowed mothers who have such children in their care. As the latter programs mature, the number of families having this insurance protection increases.

Toward maintaining family income

In addition to these payments for the support of children, the Federal income-tax law permits each taxpayer a deduction for each dependent child in figuring his taxable income. The research conducted by Federal agencies on family income and standards of living encompasses the economic needs of children and youth. The Federal laws designed to sustain income—farm price supports, requirement for the payment of a minimum wage to employees engaged in or producing goods for interstate commerce, and the unemployment insurance program—all benefit children by helping to maintain family income.

The Federal Government contributes to the control of child labor and safeguards the opportunity for children to gain their full strength and to attend school by refusing to permit the employment of children in the production of goods that it purchases and in the production of goods and services involved in interstate commerce.

In relation to the employment of youth, the Federal Government gives financial assistance to the States for vocational education and for the vocational counseling and guidance that aid youth in preparing for and finding employment suited to their capacities. It helps to safeguard youth on the job by sharing in the development of labor standards to ensure good working conditions and industrial safety for young as well as older workers.

For better living conditions

Recently the Federal Government has made substantial progress toward the development of a comprehensive housing program to aid and encourage the provision of "a decent home and a suitable living environment for every American family." This program includes loans and grants to localities to help them clear their slums and blighted areas and make them available for redevelopment; insurance of private loans for the construction and improvement of homes; loans for constructing farm housing; financial assistance for building low-rent public housing; loans to institutions of higher learning for building student and faculty housing; and research aimed primarily toward the discovery of methods of lowering the basic cost of housing, and various other types of aids to help the private housing industry reach more of the housing market. Many of these activities are designed to produce more and better housing for families with children. Liberal insurance terms are offered on loans for construction of family-sized housing. Discrimination against children is forbidden in rental projects built with Federal assistance. In low-rent public housing projects, community facilities for the health, education, and recreation of children are provided when such facilities are not accessible in the nearby community.

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Your demand—

for copies of the August-September issue of THE CHILD, our special issue on the health of school-age children has exhausted the entire free supply, and many of your requests could not be filled.

The Superintendent of Documents, Government Printing Office, is reprinting the issue, and copies will be available in about 2 weeks, at 10 cents a copy. A 25-percent discount will be given on orders of 100 copies or more. Send checks or money orders to the Superintendent of Documents, Government Printing Office, Washington 25, D. C. No additional copies for free distribution will be printed.

WHC Recordings for Sale

You may now order recordings of major speeches made at the Midcentury White House Conference on Children and Youth, including those by President Truman, Hon. Oscar R. Ewing, Dr. Benjamin Spock, Ira de Reid, Katharine F. Lenroot, and others—15 speeches in all. The set includes six 16-inch records, 33 1/3 rpm. They can be played on any standard playback machine, but not on the ordinary home record player. Price $10. Write to White House Conference on Children and youth, Washington 25, D. C. Pay in advance or upon delivery.

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HE CHILD

FEBRUARY 1951

Midcentury White House Conference on Children and Youth

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MAR 5 1951

TO YOU, OUR CHILDREN

A citizens' conference charts a course toward the future well-being of children and youth

***MARY TAYLOR**, Director, Division of Reports, Children's Bureau*

FIVE THOUSAND delegates to the Midcentury White House Conference on Children and Youth demonstrated that a conference *can* be a good way to give yourself and the country a great big hand on a great big problem.

No previous White House Conference on children had sought answers to so difficult a question: How can we develop in children the mental, emotional, and spiritual qualities essential to individual happiness and responsible citizenship, and what physical, emotional, and social conditions are necessary to this development? No earlier one had brought together so great a variety of citizen experience and background. None had such a low average age, for 400 of the delegates were under 21 years. Despite the toughness of the problem they faced, the wide disparity of age, experience, and points of view, and the number of conferees, this historic gathering in Washington, from December 3 to 7, set off a chain reaction that promises many things to many adults as well as children in the years ahead.

It may have been the solemnity of the moment that helped to make this conference the cohesive thing it was. The threat of war showed up in every session. Delegates shared with President Truman, who addressed them midway through the sessions, the consciousness that the immediate "serious crisis in world affairs overshadows all that we do." But that consciousness made even more urgent the need, as the President said, "to preserve the elements of our American way of life that are the basic source of our strength . . . We cannot insulate our children from the uncertainties of the world in which we live or from the impact of the problems that confront us all," the President had said. "What we can do—and what we must do—is to equip them to meet these problems, to do their part in the total effort, and to build up those inner resources of character which are the main strength of the American people."

From the opening to the closing hours of the conference, there was an atmosphere of dedicatedness that comes only when every member feels personally responsible for the success of a meeting. "Postmen," remarked a tired but impressed doorman as he locked the door one midnight, "postmen have nothing on these people." From 9 o'clock in the morning to well after 10 o'clock at night, through 4½ days, the delegates were hard at work, sharing experience and knowledge, and searching confidently and persistently for common ground on which to build a platform for action.

Common ground was found, and a platform was built out of the thinking, convictions, and hopes of a people dedicated to the democratic way of building things. It was built by housewives and doctors; by teachers and farmers; by priests, rabbis, and ministers; by lumbermen and psychiatrists; by high-school seniors and social workers; by American Indian mothers, Negro college presidents, trade unionists, economists, and company presidents. No more truly American document on the subject of children and youth was ever issued in our country.

Based on a firm foundation

Much of the credit for the acuteness of thinking and comprehensiveness of concept of conference deliberations and actions must go to the 2 years of preparation which went before it.

During those 2 years, every State and Territory of the United States had a conference committee gathering facts, coalescing opinions, and projecting plans for the future. A thousand counties had similar committees. Over 100,000 citizens contributed to the work of these committees, and the report of the advisory council on State and local action was in the hands of every delegate before he arrived in Washington.

Similarly, 464 national organizations had been giving conference objectives close study, and the report on their activities and recommendations was one of the conferees' tools. Thirty-seven units of the Federal Government had pulled together a picture of their services for children. An advisory council on youth participation had stimulated participation of young people in State and local activities, helped in planing conference meetings, and mobilized the thinking of young people from across the country for the benefit of delegates.

Researchers and students from over 150 universities, foundations, clinics, and other centers, helped by a fact-finding staff at headquarters, had contributed to an ambitious survey of our present knowledge of what contributes to healthy personality development and how it can be achieved. The results of this fact finding was in the hands of delegates in advance of the Washington meeting. A chart book, showing in dramatic but simple style the basic statistical facts about the children of the United States, served as a fourth preconference document.

So, when conference doors were opened on the evening of December 3 for the first general session, it was a thoughtful and well-documented group of citizens that bowed its heads for the opening invocation.

Guiding and stimulating these preparatory activities for more than a year had been a national committee of 52 members, appointed by the President, with Federal Security Administrator Oscar R. Ewing as chairman; Dr. Leonard Mayo, Mrs. Eleanor Roosevelt, Dr. Benjamin Spock, and Dr. George D. Stoddard as four vice chairmen; and Katharine F. Lenroot, Chief of the Children's Bureau, as secretary. For a year and a half a small staff, working out of headquarters in Washington, had been assisting this committee and its advisory councils.

So intense was the interest in the forthcoming conference, it had long been clear that Washington's largest meeting place would be required to accommodate the number of citizens who wished to assemble for this historic event. For this reason, the National Guard Armory, Washington's largest meeting place, was engaged. The national committee worked out the basis for selection of delegates. Invitations from the President were extended largely on the basis of nominations by the four advisory councils to the conference. Invitations also went to all members of Congress, all Governors of States and Territories, and the Commissioners of the District of Columbia; to 300 conference speakers and leaders, and to the press. Close to 300 visitors from abroad attended sessions as observers.

Looking back on the enormous distances in the Armory, on the long lines at the improvised cafeteria where most delegates ate lunch and supper snacks so as not to miss any conference session, and the great medley of meetings that took place morning, afternoon, and evening, one delegate decided that if she attends the 1960 White House Conference, she will come equipped with a motor-scooter, a picnic basket, and a hearing aid!

For spiritual guidance

In many ways delegates were given the chance to develop a feeling of group consciousness and group accomplishment. At general sessions, held at the start and close of each of the 3 days, distinguished leaders highlighted problems that the conferees should face up to in constructing their platform. (Elsewhere in this issue we excerpt remarks from those speeches.) One evening was taken over by the young delegates, whose report, "Each Is of Infinite Worth," was presented in dramatic form. Spokesmen for the other three advisory councils addressed the conference at another evening meeting. Each general session began with prayer offered by a clergyman.

To get a better close-up of the many facets of healthy personality development, delegates then divided up among 31 panel sessions. Fifteen were held simultaneously on the first full working day; 16, on the second. These information-giving sessions were conducted in various ways: some had principal speakers; some were round-table discussions; some were "buzz" sessions. To show how parent-child relationships, favorable or unfavorable, develop, a series of half-hour dramatic sketches, sponsored by the National Association for Mental Health, were played by the American Theatre Wing at two panel sessions. Delegates chose the panels they wished to attend.

But the real work of the conference went on in 35 "work groups," organized in five broad sections: I, furthering healthy personality development in children and youth; II, Furthering healthy personality development through the family, the church, the school, and other social institutions; III, Making more positive the influence of religious, social, and economic forces on personality development; IV, Furthering the healthy personality development of children in special situations; and V, Mobilizing citizens for the improvement of conditions affecting the personality development of children and youth.

Work groups held three sessions, each of them lasting a half day. In accepting invitations to the conference, delegates had committed themselves to join one work group and stay with it throughout its sessions. Each delegate had indicated his first, second, and third choices of work groups; and, so far as the size of rooms permitted, first choices were respected by the conference planning committee which made work-group assignments.

Doctors of philosophy rubbed shoulders with college freshmen; city people with those from the country; housewives with top-notch educators; social workers with businessmen. Coming from all kinds of places, with all kinds of backgrounds, and ranging in age from 14 to—well, no one knows the age of the oldest delegate—members of each work group had one thing in common: a firm determination to find a basis for common agreement on some aspect of the great problem before the conference.

"Only a miracle," one foreign visitor, unused to American ways, apprehensively predicted, could make something emerge from such heterogeneous groups of people. But he was wrong. Each group, after ex-

After Nation-wide preparation sparked in 1946 by the National Commission on Children and Youth, the Midcentury Conference drew to Washington 5,000 citizens in the largest gathering on children's problems ever held in this country. Here is a general session.

ploring itself, knuckled down to its real business, and by the end of its third session had envolved a series of recommendations which became the ground plan for the platform later adopted by the whole conference. Work-group recommendations moved to the section leaders, who consolidated them into proposals which went to a conference recommendations committee. Working through most of the night, this committee was ready, on the morning of the last conference day, with a draft platform.

Right there, on the final day, democracy went into high gear. The program called for an hour and a half of discussion of the proposed platform. In the great American tradition of free speech, it seemed that everyone wanted to speak his piece. Microphones strategically placed around the hall gave delegates many chances to be heard. Votes were taken on issues on which there was sharp division, on rulings of the chairman with which delegates disagreed, on timing of debate. So intensely determined were the delegates to make this platform something that was their own, the scheduled afternoon program was canceled in favor of continued discussion of the platform from the floor. All day, it was an American "town meeting" in the best traditional form. By the close of the day, these 5,000 delegates had adopted a document, including a Pledge to Children, which represented their own group wisdom, not something that had been handed to them. "If this is democracy," an international observer commented, "I don't wonder you are proud of it and want to fight for it."

Possibly no two histories of the Midcentury White House Conference on Children and Youth will read quite the same, so infinitely varied were the impressions any one of the 5,000 delegates could take away with him. But running through them all are pretty sure to be a few common strands.

Democracy's great responsibility "to produce socially minded cooperative adults without sacrificing individuals—a more difficult task man has never faced before"—was inevitably a central concern of the conferees. In scores of ways, they explored the ingredients of a healthy personality, the interpersonal and social forces that work for and against its development, the kinds of help that children and youth have a right to expect from their families, schools, churches, and government if they are to have a chance to grow in physical, mental, emotional, and social health.

All institutions and individuals touching the lives of children and youth, it was stressed over and over, share in the great task of creating an environment in which healthy personality has a chance to bloom. That calls for more and better-trained professional workers; workers who are trained not merely in their own specialty but also in an understanding of how the normal child grows in health; workers who are eternally conscious that they are dealing not just with the head, or body, or mind, or heart of a child but with his whole person.

Spotlight on parents

Major responsibility for nurturing this healthy personality, it was generally agreed, rests with parents. Recognizing this, most of the groups brought a large measure of sympathy and understanding to these central characters of the conference. "Experts are helping mothers too much," one delegate observed. "Mothers are not ready for all the psychology and psychiatry they're expected to practice on their children. We jump from one feeling to another and end up feeling completely inadequate." Against that warning was the assurance that came repeatedly: "If children know they are fundamentally liked, accepted, and believed in, they can stand the mistakes their parents inevitably make." "Don't keep the child in the oven or in a refrigerator," cautioned one delegate, "just keep him warm with affection and understanding." One of the ways of helping parents who are already doing a good job to do a better one might be "well-family conferences," comparable to well-baby clinics. Journalists might help, too, a group said, by "publicizing parents who have made an exceptional success, instead of writing so much about problem children and broken homes." Still another group heard family allowances extolled as an aid in building family strength.

"In democracies youth face difficulties greater in some ways than in totalitarian states because freedom, plus insistence on personal responsibility, creates an element of conflict," one delegate reminded his group as they explored conflicts in personality development. A basic conflict noted by many groups was the one between theory and practice in interracial relations. "Prejudice and discrimination," said one speaker, "are contrary to the findings of scientific knowledge, inimical to the teachings of religion, and an obstacle to the working of a democracy." "The fact that people with prejudices seem to possess temporary gains from their prejudicial action," another delegate commented, "is overbalanced by the long-run loss to the community." So deeply did the youth delegates to the conference feel about making practice conform to principle that they chose to protect their members from any racial prejudices by living all together in barracks furnished by the Army. In a resolution which they submitted to the conference, their advisory council called on all

In the great hall outside the main auditorium, exhibits suggested graphically the activities of groups — governmental, international, and voluntary — working with children.

organizations connected with the conference to "take positive action to eliminate the cause of discrimination and to foster an aggressive program of civil rights."

War, and defenses against it, naturally were in the forefront of the thinking of many delegates, many work groups. "We must remember," cautioned one panel speaker, "that the most important security we can provide for our children and youth is the security against physical annihilation." At the same time, another group of delegates asked itself: "Are we going to be carried away with this heavy industrial and military need, and sell our children down the river?" Various work groups came up with specific suggestions on how to avoid this outcome. "The armed services," said one, "should use the individual according to his talents, background, and physical ability." "Our young adults should be encouraged to stay in school as long as possible until mobilization takes them away," was another suggestion. "We need more association and identification with men for the preadolescent boy," said another. "Maybe," said a speaker, "we should make strong efforts to keep mothers in the home, rearing their babies and young children," rather than enlist them for war work. One youth delegate capped the discussion on what effect mobilization has on youth by saying to her group: "It breaks up our homes, frightens us about the future; our plans are all messed up, it delays progress. . . But bet your boots, the young people—the teenagers—will work to make our country stand for the ideals which we have learned in a real democracy."

Prime emphasis was placed on spiritual values in the growth of a healthy personality throughout the discussions. The youth delegates placed it top on their list of essentials. "Spiritual values," the report of the advisory council on youth participation had said, "should influence every action of our life and have a day-by-day meaning." "Religion cannot be compartmentalized," one work group said. "It must be a pervasive influence extending over all of life and to all our youth." "Unless and until the criteria which religion provides for all races and conditions of men are commonly accepted, democracy itself cannot be on a firm foundation." Delegates referred to the "fact finding" materials which had been given them and which emphasized the pervasive importance of the ethical and moral affirmations of religion in developing sound values and a sense of security and well-being in children and their parents. While the vote on the final platform was strongly in favor of separation of church and State, particularly in public education, the function of the church in giving meaning to life, in helping to resolve the problems of youth, in serving as "liaison between God and man," was stressed again and again.

Many observations of specialists and of laymen on these vast and intricate problems of personality development may now have a sound of finality. Actually there was throughout all the sessions of the conference a very present sense of the inadequacy of our knowledge of the way children do or should grow. Strong pleas for more research were heard from many speakers. At the same time, as one distinguished psychiatrist put it, "Though our knowledge is incomplete in most aspects of personality development, there is plenty of knowledge to do an infinitely better job than is being done today." "There is an art as well as a science of application," another expert pointed out. Theories that are insufficiently tested, research results that are inadequately collated, and psychological resistance to truth that "hurts" are three of the blocks to effective application.

Delegates spread word-of-mouth reports

In these short pages only a "tester" can be given of the flavor of a conference that ranged over many of the most fundamental questions facing this midcentury period, and that involved the participation of so many people. A much more complete summary of conference proceedings will be available by the end of April. But even more important than the official report which will be forthcoming are the personal ones which all of the 5,000 delegates are spreading right now in their own communities and through their many organizational associations. The group spirit which fired the Washington conference cannot help but light the way to a deeper understanding, a broader kinship, and a higher resolve among all who cherish and serve children and youth in the decade ahead.

typical information panel is studying how prejudice and discrimina-
affect personality. Thirty-one panels met during the conference.

A welfare worker from Madras, India, meets two youth del
She is one of the 292 international observers, from 41 cou

WHAT THE CONFERENCE RECOMMENDS

Believing in the primacy of spiritual values, democratic practice, and the dignity and worth of every human being, and recognizing that these are essential to individual happiness and responsible citizenship, we have come together to inquire—

How the necessary mental, emotional, and spiritual qualities may be developed in children, and

How the physical, economic, and social conditions favorable to such development may be assured.

And having found that children require for their fullest development—

Regard for their individual worth and sensitive respect for their feelings from all who touch their lives;

Loving care and guidance from mothers and fathers, who have a sense of the privilege and responsibility which parenthood involves, and who have confidence in their own capacity to to rear a child;

A secure home that is free from want and dread of want, and provides all family members with a satisfying physical, aesthetic, social, and spiritual environment;

A community whose citizens are dedicated to establishing the values and practices that make life meaningful and abundant for children of all colors, creeds, and customs, and to cooperating in an endeavor to express these values and practices in daily living;

Full access to health, educational, recreational, social, and religious services and programs, directed toward the well-being of all they serve;

Concern on the part of all citizens for all children;

Devotion to the pursuit of knowledge and the wide application of that which is known.

If they are to grow in—

Trust in themselves and others;

Independence and initiative coupled with a true sense of being related to others;

Satisfaction in bringing individual and shared tasks to completion;

A sense of personal destiny of the responsible roles they will eventually play as parents, workers, citizens;

The capacity for the love that underlies the family and that ideally comes to embrace all mankind;

Creativity that brings into being new life, new relationships, new values, and new things of beauty and usefulness, and cherishes them for their worth;

Integrity that sees each life as personally meaningful within the period of history in which it is lived, and in relation to enduring values.

We therefore recommend with respect to—

1 Furthering healthy personality development generally in children and youth

1 That research on child development and adjustment be expanded and that such research include longitudinal studies in relations and factors that affect behavior and adjustment, so that a continuing understanding of infants, children, and youth and a sound basis for practice will be provided; that public and private agencies give support to extending research pertaining to healthy personality with attention to the synthesis, interpretation, and dissemination of the findings.

2 That greater emphasis be placed by the various professions on utilizing methods and seeking new means of bringing the parents into thinking and planning with and for their children.

3 That education for parenthood be made available to all through educational, health, recreation, religious, and welfare agencies maintaining professional standards and staffed by properly qualified individuals.

4 That specialists and agencies take every opportunity to foster and increase parents' feelings of satisfaction and self-confidence in their ability for child rearing; that material concerning the growth and development of children be made as reassuring and nontechnical as possible, and that false standards of perfection not be held up.

5 That elementary, secondary, college, and community education include such appropriate experiences and studies of childhood and family life as will help young people to achieve the maturity essential to the role of parenthood.

6 That there be further study of the underlying causes of broken homes and the increase in divorce.

7 That children be provided with opportunities that are wide in range and challenging in nature, emphasizing exploration, participation, and social experience in an environment that is rich and stimulating; and that expectations of achievement be in harmony with each child's ability and growth.

8 That all professions dealing with children be given, as an integral part of their preparation, a common core of experiences dealing with fundamental concepts of human behavior, including the need to consider the total person as well as any specific disorder; the interrelationship of physical, mental, social, religious, and cultural forces; the importance of interpersonal relationships; the role of self-understanding; and emphasis on the positive recognition and production of healthy personalities and the treatment of variations; and that lay people be oriented through formal or informal education to an understanding of the importance of the foregoing concepts.

9 That steps be taken at National, State, and local levels to improve

the facilities and increase the output of professional schools preparing persons for services to children.

10 That more energetic efforts be made by both public and private organizations for support of selective recruitment and training of professional workers and for an extensive program of scholarships.

11 That professional workers be trained in such a way that they will understand and respect other professional skills and contributors so that they may work together to further community growth. Some of the ways this might be achieved are:

a In all levels of undergraduate education, students should receive broad preparation in the knowledge of human growth, behavior, and motivation which ought to be common knowledge for all students. This would also serve as a background for professional education.

b In schools preparing for professional work, there should be included in the curriculum through both the classroom and field experience opportunities for cooperative work on problems common to all professional interests, including study in human growth and change and in family counseling.

c The practicing professional worker should further his training by seeking, utilizing, and promoting opportunities to relate to and participate with other professional and citizens' groups in resolving problems of the individual and the community.

d Orientation programs should be planned for all professional persons and interprofessional groups in the community.

12 That ways and means be found for the formal and informal inservice education of professional people and that information on promising practices be widely disseminated.

13 That an inquiring attitude be maintained toward all services, with appropriate provision at all levels for continuous scientific study of needs, objectives, alternative methods, and effectiveness of programs.

2 Furthering healthy personality development through the family, the church, the school, and other social institutions

14 That prompt action be taken at the national level to provide funds supplementing those of States and localities for the early development of adequate local health service throughout the country, such action being particularly needed because of the physical and mental effects of mobilization and war on mothers, children, and youth.

15 That all States establish standards for the hospital care of mothers and children, in order to assure the quality of care which modern science knows how to give; and that these standards take into account the importance of avoiding unnecessary distress and anxiety.

16 That further Federal aid be provided to the States for educational services, in tax-supported public schools, without Federal control, to help equalize educational opportunity; the issue of auxiliary services to be considered on its merits in separate legislation.

17 That racial segregation in education be abolished.

18 That it be made possible for qualified youth to obtain college or university education which would otherwise be denied them because of inability to pay.

19 That as a desirable supplement to home life, nursery schools and kindergartens, provided they meet high professional standards, be included as a part of public educational opportunity for children.

20 That school lunches be provided and that children unable to pay for their lunches be furnished them free, without being differentiated from the children who pay.

21 That local boards of education accept full responsibility for planning and providing adequate educational programs and services, including special services, to meet the needs of children with physical and mental limitations, and that State departments of education accept responsibility for leadership service in realizing this objective.

22 That guidance and counseling services in schools, employment offices, and youth-serving agencies be strengthened and extended, and that such services take into account emotional factors involved in vocational adjustment and aptitudes for specific jobs.

23 That, recognizing that knowledge and understanding of religious and ethical concepts are essential to the development of spiritual values, and that nothing is of greater importance to the moral and spiritual health of our Nation than the work of religious education in our homes and families, and in our institutions of organized religion, we nevertheless strongly affirm the principle of separation of church and State which has been the keystone of our American democracy, and declare ourselves unalterably opposed to the use of the public schools, directly or indirectly, for religious educational purposes.

24 That the churches of various faiths coordinate, strengthen, and expand their religious services and activities with particular respect to rural areas and areas of special economic need.

25 That youth have an equal chance with adults to participate in planning and carrying out recreational activities, and that as a practical aid to such planning, States be encouraged to establish official State recreation agencies to provide counseling, information, and assistance to communities, particularly small towns and rural areas.

26 That more emphasis be put on the effects of recreational and creative activities on the personality of the individual, and that in all neighborhoods where children and youth reside, recreation centers be provided under professional and voluntary supervision.

27 That, as an aid to the economic stability of children and their mothers, the Old Age and Survivors Insurance program be further extended to cover workers not presently included, and benefits made more adequate; and that similar improvements be made in State unemployment insurance laws.

28 That Federal grants to States for public assistance be varied with the financial ability of the States but made sufficient to protect children's personalities from the ill effects of inadequate income.

29 That restrictive eligibility provisions be eliminated from public assistance programs so as to provide assistance to all children in need.

30 That there be a comprehensive study of the present body of law relating to children and families and the methods implementing such laws; the study to include laws that impede the progress of Indians in fields of social and cultural advantage.

31 That law schools include courses on family law and the relation of the law to other professions, and that schools of social work include courses on the law and its philosophy.

32 That, in accordance with State-wide standards, courts of superior jurisdiction, having judges qualified in the law and with an understanding of social and psychological factors, and having qualified probation staff and auxiliary personnel, be available for all cases of children with problems that require court action in rural and urban areas.

33 That standards be developed for juvenile services in police departments.

34 That the preventive and treatment functions of social agencies, police, courts, institutions, and after-care agencies be coordinated so as to insure continuity of service.

35 That States and other appropriate public bodies establish and enforce standards covering the employment of youth in all occupations, such standards to include minimum age and wages, as well as hours of work, night work, protection from hazardous occupations, and provisions for workmen's compensation; and that, under these conditions, employers, in cooperation with labor, be urged to provide appropriate work experience for youth on a part-time basis.

36 That one department in each State government, whether it be welfare, health, or education, working in close conjunction with the other departments concerned, set up all-inclusive minimum standards for all day-care centers, nursery schools, and kindergartens.

37 That appropriate public bodies establish minimum standards for licensing or authorization with respect to plant, program, and staff, for all child-care and preschool groups.

38 That a continuous program of education regarding the role of social service in adoption be carried on for the general public and for the professions involved, to the end that effective safeguards be achieved for the protection of the adopted child, his natural parents, and his adoptive parents; that existing legislation be strengthened and, if need be, new legislation enacted to assure such protection; and that qualified adoption agencies, local and State-wide, voluntary and public, be strengthened and developed to further assure such protection.

39 That appropriate public bodies set minimum standards for agencies and institutions providing foster care for children, whether foster day care or full-time care, and provide for authorization or licensing and supervision to maintain those standards.

40 That all programs for children and youth with handicaps be expanded to provide for physical, mental, emotional, and occupational needs.

41 That children of migrant and seasonal workers be given all the protections and services available to other children, with special regard to transportation, housing, sanitation, health and educational services, social benefits, and protection under labor laws.

3 Furthering healthy personality development in relation to the influence of certain social and economic forces

42 That all groups concerned develop and maintain programs for protecting the healthy personality of children living under the stress of defense preparation.

43 That the sacrifices demanded in the present emergency be shared by all individuals and groups in the population and that the services of men with physical and other disabilities be utilized in some capacity without the use of categories such as 4-F.

44 That more and better educational and recreational opportunities be made available for young adults in civilian and military life.

45 That schools, labor, industry, and other community agencies and the military services improve and expand their personnel, evaluation, placement, vocational-guidance and counseling activities to serve the interests of young people and to promote the over-all development and efficient utilization of our human resources.

46 That adequate allowances be provided for wives and children of servicemen.

47 That the participation of children and youth in community activities during times of stress be in accordance with their stage of development and designed to minimize their anxieties.

48 That governmental and voluntary agencies work to meet the needs of the wives and children of personnel in the armed forces moving to new communities, in order to insure their absorption into community life and to provide adequate housing, health, educational, recreational, and spiritual services to meet their needs.

49 That specific efforts be made to bring lower-income groups up to a higher-income level and to increase their real income by providing a greater variety of community services; such expansion of services to include children in all the States and Territories and the District of Columbia.

50 That there be authoritative exploration of methods of improving the economic situation of children in families with inadequate incomes, with particular attention to family allowances, tax exemptions for children, and expenses of working mothers.

51 That the full program recommended by the President's Commission on Civil Rights be supported because it represents our faith in and practice of democracy, and further, that prompt steps be taken to eliminate all types of racial and religious segregation, and that this conference through its most appropriate channels appeal immediately to the Federal Government to abolish segregation in the Nation's capital, making Washington an example to the world of a truly working democracy without discriminatory practice on the basis of race, creed, color, or national origin.

52 That to insure the welfare of all children the following specific

measures be taken to provide a well-rounded comprehensive housing and community-development program:

a Maximum emphasis should be placed on maintaining standards adequate for health, comfort, and decency in both private and public housing.

b The construction of 810,000 low-rent public housing units should proceed at full speed in order to provide much-needed housing for low-income families now living in slums.

c A cooperative housing program should be developed, specifically geared to meet the needs of middle-income families who are ineligible for public housing.

d Our national housing program should meet the requirements of families, not only in every income group, but also in every type of community, rural and urban, and of every size from the largest to the smallest.

e The slum clearance and urban development and redevelopment program, now getting under way with Federal assistance, should be supported as an integral part of over-all community planning.

f Adequate housing for families of defense workers of middle and lower income should be regarded as an essential criterion in providing defense housing facilities in a period of mobilization.

53 That development of new housing facilities give special attention to health, recreation, and social needs; and, to the extent that private industry does not provide suitable housing for low-income families, such housing continue to be developed by governmental agencies.

54 That, in view of television's unprecedented growth and its potential as a medium for mass education, the television industry and all educational, health, and social agencies seeking to use this medium accept their great social responsibility, and further, that this principle apply also to the other media of mass communication.

55 That the Federal Communications Commission reserve television channels for noncommercial educational television stations so that some part of the limited number of frequencies to be allocated by the Commission may be reserved for educational uses and purposes which contribute to healthy personality development.

4 Furthering healthy personality by mobilizing citizens for the improvement of conditions affecting children and youth

56 That community groups and community leaders reexamine their attitudes and procedures in the light of this conference, and make appropriate adaptations and changes.

57 That in order to insure proper assessment, creative planning, and appropriate action with respect to meeting the needs of children and youth communities undertake the following tasks on a continuing basis:

a Developing broad community interests.

b Obtaining the broadest possible community sponsorship.

c Obtaining, where necessary, technical assistance in planning and carrying out the program.

d Initiating or organizing studies and gathering facts that are focused on specific problems according to priorities.

e Interpreting the facts, and informing the community as to their significance.

And that since goals and methods are closely intertwined, in undertaking these tasks the methods used be based on the following principles:

a People as individuals and as groups should be helped to help themselves; professional workers should find their role in giving this kind of help.

b Differences and stresses that may be present should be recognized and utilized positively.

c Broad-based participation of all groups without discrimination as to age, sex, race, creed, national origin, or economic level should be developed.

d Fact finding should be used as a part of a total educational process.

e Channels of communication between individuals and groups should be provided for the purpose not only of furthering common social objectives but also of improving relations between groups.

f Since the community is served by both public and private agencies, which have a common concern for meeting the needs of children and youth, the endeavors of both should be utilized in planning, assessment, and financing.

58 That the citizens of every community accept responsibility for providing and maintaining adequate programs and facilities with professional personnel for education, health, and social services, and that, in the development of such programs, full and appropriate use be made of all voluntary and public resources.

59 That participation in planning in the community begin in the schools and in other institutions, in order that children, youth, and adults learn the importance of voluntary participation and responsibility for community leadership.

60 That all interested groups work in partnership to recruit, train, and use volunteer leaders for community programs, with special attention to using young people in appropriate ways.

61 That, since citizen participation is essential for effective community services for children and youth, citizen advisory boards and similar groups representative of the community, when not already provided, be established for public as well as private services, and that every effort be made to enable and secure participation by a cross section of the citizenry; and further that educational institutions and other groups emphasize the importance of participation by volunteers as a basic factor in citizen responsibility.

62 That communities foster cooperative community bodies representative of all community interests to study and advance better conditions and opportunities for young workers.

63 That citizens be encouraged to support adequate appropriations and qualified staff to administer and enforce basic legislative standards of States and Territories and other appropriate public bodies, covering the employment of youth.

64 That, recognizing that youth has rights and responsibilities for better community living, progressive opportunities be provided for young people to participate vitally in community activities and planning in order that they may have early preparation and experience for leadership and community service; and further, that the professional workers accept their responsibilities to stimulate the community to see that these opportunities are provided for youth.

65 That youth representatives be placed on community boards of various agencies, in order that they may participate in the planning, developmental, and operational phases of the total community programs.

66 That, in recognition of the importance of cooperative work in behalf of children and youth among the governments and peoples of the world, full support be given to voluntary efforts and governmental programs of an international nature.

67 That immediate, vigorous, and continuing work be undertaken to provide for the organization and financing of National, State, and local programs which would put these recommentations into action.

RESOLUTION ON FOLLOW-UP PROGRAM

Whereas the President of the United States, who called this Midcentury White House Conference, has stated that "ways to help our children and young people become mentally and morally stronger" and develop into the "self-reliant individuals" that are the strength of our democracy, are "essential for the progress of mankind" and the preservation of "our own liberty as a Nation," and

Whereas the President has stated that "in the days ahead—we will have to make special efforts to see that children get a fair chance at the right start in life" and has asked this conference to proceed immediately toward such goals, and

Whereas over 100,000 citizens in all States and Territories have studied ways of improving the well-being of children in their own communities, and

Whereas this White House Conference has so dramatically demonstrated the pressing need for the better application of that which we know and that which we assume to be good as well as the importance of filling by further research the wide gaps in our knowledge of human and social behavior, and

Whereas the follow-up on the recommendations and implications of the findings of the Midcentury White House Conference depend upon the fullest partnership of voluntary and official effort, and

Whereas this White House Conference has demonstrated the need for more effective communication between the National, State, and local levels, and

Whereas there is need to establish a continuity of effort in follow-up, and

Whereas the National Committee of the White House Conference, its advisory councils, and delegates attending the December meetings have recommended that machinery be authorized to implement follow-up:

Be it resolved that this conference recommends approval of the following principles in effecting appropriate action in follow-up.

1 That the chief operating groups upon which the responsibility for follow-up should fall will be existing organizations — National, State, and local.

2 That the chief purposes of the follow-up effort should be to disseminate the findings of the conference, stimulate action on its recommendations, and promote research designed to fill the gaps in knowledge which the conference has brought to light.

3 That the participation of youth and the interdisciplinary approach demonstrated in this conference should be maintained and further developed.

4 That a national committee should be formed as an advisory and consultative group. Such a committee should work through all the groups which have a primary concern for the well-being of the Nation's children and youth. It should be made up of individual citizens asked to serve in their own right rather than as representatives of organizations or interests and determine its own methods of financing.

5 That provision for continuity should be implemented by—

a Including on this new committee five selected members from each of the present advisory councils wishing to participate in follow-up, members from the presently organized national committee, and members at large, and

b Providing for State and local follow-up organization.

6 That ongoing activities should be effected by this national committee through an advisory council for participation of national organizations and an advisory council for State and local action and through such technical committees as may be indicated, and that the committee should provide for appropriate cooperation with governmental groups at all levels.

7 That the national committee here proposed should of necessity be allowed discretion, within the framework of the purposes here set forth, to make such changes as will assure the attainment of the conference objectives.

8 That authority for setting up this follow-up program should be given to the National Committee of the Midcentury White House Conference.

CONSENSUS

Recognizing that this is a time of crisis posing the very issue of survival, and desiring to summarize the aspirations embodied in the recommendations and to declare the spirit in which the recommendations will be interpreted and followed, the conference adopted the following statements as representing a consensus of the group and an expression of its unity of purpose:

1 The full development of the whole child is the basic philosophy and ultimate aim of all recommendations.

2 All services, programs, and facilities for children and young people should be provided without discrimination as to race, creed, color or national origin.

3 Continuing emphasis on research and its application is essential.

4 Qualified personnel is needed in sufficient number to staff services and programs for chidren and youth.

5 Youth should be included as full participants in all appropriate community activities.

6 Effective partnership between voluntary and governmental agencies is needed in the furtherance of this program.

7 Effective teamwork by the professions is essential to development of healthy personality.

8 Full participation of all citizens is necessary in providing and sustaining all programs and services recommended by this conference.

IN PARTNERSHIP WITH YOUTH

MARGERY CUNNINGHAM, Assistant Director of Communications, Midcentury White House Conference on Children and Youth

NOT LONG before the December meetings of the Midcentury White House Conference on Children and Youth, a Washington high-school girl who had been active in the preparatory work asked Katharine F. Lenroot, Chief of the Children's Bureau, "Why weren't young people permitted to join in any of the earlier White House Conferences?"

"I guess because the adults weren't smart enough to think of it," Miss Lenroot answered.

Given the opportunity to participate, the teen-agers reveled in it. In the preconference period, many worked actively with State, county, and local committees, and in their own organizations, helping to make the surveys on which the conference would base some of their discussions.

The 75 young people who made up the advisory council on youth participation came to Washington in a body twice during the year before the meetings, to exchange ideas on the conference work they were doing back home and to plan how they could take part most usefully in the December meetings and in the follow-up.

At the second of these meetings they attacked a problem that wasn't on their agenda but that was bothering many of them so much that they felt they must do something about it right away. And so they passed a resolution deploring the racial prejudice and discrimination that they saw in their various home communities.

Then, arming themselves with the only weapon available to them at the moment, they decided that when they came to Washington for the conference they would stay away from establishments that would not accept all of them.

They returned to Washington in December, 500 strong, and at panels and work groups they were centers of interest as they sought their chances—side by side with adults with national reputation—to ask questions, to report their conclusions, and to take issue when they didn't agree.

Youth speaks up

The youth delegates contributed something to every subject, but they seemed particularly vocal on community organization and planning.

If these boys and girls are typical, then the youngsters in our American communities want to work with adults and are doing so wherever they get the chance.

At the conference they decried the tendency they see in adults to give only lip service to the idea of youth participation in community affairs. One young delegate from Georgia told his work group that "older people ask for our opinions when they are planning something that concerns us, such as recreation projects, and then do not pay any attention to our opinions when they get them." In a discussion of causes of conflict between youth and adults, a Virginia student said that too often adult boards and groups pick out "safe" young people, for fake participation, instead of letting youth elect their own choices.

Both youth and adults benefit

Toward the end of the conference all the young delegates got together to evaluate their experiences and to plan follow-up action. As a group, these boys and girls felt they had benefited through hearing how adults feel about youth problems; through learning to work with adults, getting actual experience; through the general knowledge they gained; and through the chance to hear of proposed solutions to problems they know exist in their own communities. In turn, they felt they had contributed by giving adults their own viewpoint on youth problems, and by calling adults' attention to further ones.

As for follow-up action, the young people voted to meet once more to evaluate progress; and they urged that youth members be included on follow-up committees at all levels, from national to local.

The young people passed a resolution registering their concern about the spiritual welfare of children and youth, and asking the conference "to state clearly its faith in the fundamental principles upon which American democracy is based and to confirm our faith in the authority of a Supreme Being, in the innate dignity of all men, and in the application of this faith to all areas of life."

They did not put it into the record in so many words; but as to their own faith in American democracy and in their individual and collective futures there is no doubt.

"When we come back in 1960 as adults . . ." they said to each other, and to 1950's grown-ups. Time after time they prefaced remarks with, "by the time of the next White House Conference . . ."

Clearly, they expect to be active in 1960 projects in behalf of our children and youth. And they have no doubt that they will be well-adjusted, contributing citizens of a democratic Nation and of a world which is a better one for all.

AND WE QUOTE—

HARRY S. TRUMAN

President of the United States

"Our teachers — and all others who deal with our young people—should place uppermost the need for making our young people understand our free institutions and the values on which they rest. We must fight against the moral cynicism—the materialistic view of life — on which communism feeds. We must teach the objectives that lie behind our institutions, and the duty of all our citizens to make those institutions work more perfectly. Nothing is more important than this. And nothing this conference can do will have a greater effect on the world struggle against communism than spelling out the ways in which our young people can better understand our democratic institutions, and why we must fight, when necessary, to defend them."

●

GEN. CARLOS P. ROMULO

Secretary for Foreign Affairs, the Republic of the Philippines

"If the Charter of the United Nations were faithfully complied with, this and succeeding generations would be saved from the scourge of war. Fundamental human rights, the dignity and worth of the human person, and the equal rights of men and women as well as of nations large and small would be secure. A rule of law based on reason and equity would be maintained. Social progress and better standards of life would be attained in a context of larger freedom. . .

"That is the kind of world to which the children of today are entitled. It is the kind of world which we are trying to build for them through the United Nations."

●

OSCAR R. EWING

Federal Security Administrator

Chairman, Midcentury White House Conference on Children and Youth

"The theme of our conference is simple, yet far-reaching: How to provide each child with a fair chance to achieve a healthy personality. Our purpose is to consider what we need to do in order to develop in children the mental, emotional, and spiritual qualities essential to individual happiness and responsible citizenship; and how the physical, economic, and social conditions of our society affect this great goal.

"We aim to further the development of a healthy personality through the contributions of family life, the church, the school, health services, social services, vocational guidance, and placement services. We are exploring, at the same time, economic forces; working conditions; leisure time; and the influence of the law, the courts, and the protective services.

"We have to explore the spiritual values of our people and our society; the effect of conflicting standards; the influence of the neighborhood; the effect of family income; the significance of artistic expression; the impact of the mass media of communications, such as the press, radio, television, movies, and the like; and the effect of mobilization and possible war.

"We aim to further healthy personality development of children in special situations—children in families with inadequate income; children with part-time parents; children on the move; children with severe mental and physical limitations; children with serious emotional disorders; and children who rebel.

"We aim, finally, to determine how a community can assess what needs to be done in planning creatively for young people; how the energies of business, labor, civic, and other special groups may be enlisted in meeting the needs of children; how democratic leadership functions in such community planning and action; and how best to implement the recommendations and findings that come out of this conference."

●

ALLISON DAVIS

Professor of Education, University of Chicago

"Teachers misunderstand and resent the slum child's fighting, just as they do his cursing, his so-called precocious sexual behavior, and his dialect. In lower-class families, however, the parents themselves have taught their children to fight not only children of either sex but also adults who 'make trouble' for them. If the child or adolescent cannot whip a grown opponent, the mother or father will join the fight. In such lower-class groups, an adolescent boy who does not try to be a good fighter will not receive the approval of the father, nor will he be acceptable to any play group or gang. The result of these cultural sanctions is that he learns to fight and to admire fighters. The conception that aggression and hostility are neurotic or maladaptive symptoms of a chronically frustrated adolescent is an ethnocentric view of middle-class psychiatrists. In lower-class families, physical aggression is as much a normal, socially approved, and socially inculcated type of behavior as it is in frontier communities."

DR. MARGARET MEAD

Associate Curator of Ethnology, American Museum of Natural History

"American children are growing up within the most rapidly changing culture of which we have any record in the world, within a culture where for several generations, each generation's experience has differed sharply from the last, and in which the experience of the youngest child in a large family will be extraordinarily different from that of the first-born. Mothers cannot look back to the experience of their mothers, nor even to that of their older sisters; young husbands and fathers have no guides to the behavior which they are assuming today. So long standing and so rapid have been these processes of change that expectation of change and anxiety about change have been built into our character as a people. Our homes have become launching platforms from which our children set out on uncharted seas, and we have become correspondingly more anxious that they should be perfectly equipped before they go."

•

LEONARD W. MAYO

Director, Association for the Aid of Crippled Children

"If we are to make substantial advances in application in the next decade we must work consciously and assiduously to develop the following:

"1. A scientific attitude of mind; not an ordinary open mind, but a searching one; not just an inquiring mind, but a mind and a heart that have what Einstein has called "a passion for comprehension"; a mind that does not reject simply because it does not know, which does not let bias rule, nor allow insistence on one point of view to have sway.

"2. A far better synthesis of available knowledge than we have at present; and a better collation of the results of current research in both the physical and social sciences . . .

"3. The recognition that there is an art as well as a science of application . . .

"4. An identification and cultivation of the channels through which knowledge must be disseminated and applied . . .

"5. Intelligent team work. . .

"6. We need foundations and universities which will recognize that we have now reached the place where demonstration and experimentation in the spirit of, and with the methods of, research are needed at the point of application quite as much as pure research is needed in the acquiring of new knowledge."

•

DR. BENJAMIN SPOCK

Co-Director, Rochester Child Health Institute, Rochester, Minn.

" . . . Though our knowledge is incomplete in most aspects of personality development, there is plenty of knowledge to do an infinitely better job than is being done today. The most obvious and immediate needs, to my mind, are to provide more and earlier help for emotionally neglected children and to improve our schools. I think the most fundamental question is: Why are so many parents unable to enjoy their children? We know what some of the causes are in individuals and that individual psychotherapy can be effective in certain cases. But we have not studied the problem from a broad public-health point of view and we have not begun to think of broad solutions. One of the investigations will be to see what educational methods, from nursery school through college, can do to keep alive the delight in children which is usually present in childhood, and to bring the boy and girl to adulthood with the feeling that there is no more important, honorable. and soul-satisfying job than having and caring for children."

•

KATHARINE F. LENROOT

Chief, Children's Bureau

Secretary, Midcentury White House Conference on Children and Youth

"White House Conferences have seen their tasks as beginning—not ending—with a closing session in Washington. This conference has a more adequate basis for follow-up than any previous conference, because it has involved so many citizens in preparatory work and because it surpasses all others in the number and representative character of its membership. The plan for follow-up adopted today should enlist the continuing activity of all who have contributed to the success of this gathering. Its influence should result in action affecting all of our children and young people, wherever and under whatever circumstances they live.

"The conference will so affect their lives if every person who has had the privilege of participation in it will hold himself or herself personally responsible for a vital share in follow-up work. The conference findings and recommendations, if they are to be made effective, require renewed emphasis on the privileges and obligations of parenthood; review of the focus and methods of scientific research; reorientation of professional education and professional service in many fields; examination of the ways in which our services are organized; review of the distribution of functions among the different agencies and the manner of their coordination between public and private agencies; more comprehensive and representative community planning; increased financial provision for public and private services; and above all, more effective means of citizen action."

A CONFERENCE WITH A FUTURE

MELVIN A. GLASSER, Executive Director, Midcentury White House Conference on Children and Youth

HERE'S one conference, wrote an astute newspaper reporter to her paper, that "came in with its sleeves rolled up and went out with them rolled up higher."

Already, reports of follow-up plans and activities suggest that delegates to the Midcentury White House Conference, together with the folk back home who shared in the 2 years of preparation for the conference, have rolled their sleeves well above their elbows!

"Little White House Conferences" are in the making in many States. Kansas has already had one, at the annual meeting of the State Council for Children and Youth, in December. The Connecticut Commission on Children and Youth also met that month to launch its postconference action. Idaho is working up four regional meetings for 1951. Indiana is bringing together 1,000 conference workers from all over the State for a thorough review of conference recommendations. Maryland has launched three regional meetings, with 28 delegates from each county — half of them young people.

These are just samples of what may be expected to happen in many States in the coming months. Stimulating this activity will be the advisory council on State and local action. State chairmen reported that at least half the State committees have funds in hand with which to get started on follow-up activities, and two-thirds have specific plans on what they want to do next.

National organizations, too, have moved ahead. Immediately after the conference, Salvation Army delegates got together to ask themselves which of the conference recommendations applied especially to the work of their organization. They came up with a sizable list of projects on which they might profitably put special emphasis. One of the things they plan to do, for instance, is to reexamine their training programs to see if they give enough attention to instruction in child growth and development and in family counseling. The General Federation of Women's Clubs is launching a Nation-wide community improvement contest, to "Build Freedom With Youth." Through this contest, the 14,500 member clubs will be encouraged to develop, in partnership with young people, cooperative community improvement activities, such as recreation projects, vocational-guidance programs, better-citizenship activities. This enterprise was publicly launched in Washington in mid-January. The American Legion's Child Welfare Conferences, and also the American Public Welfare Association, will feature the White House Conference at regional meetings.

National associations active in follow-up

Professional as well as lay groups intend to turn the White House Conference experience to good account through their national organizations. The American Home Economics Association began its follow-up work with a 2-day meeting immediately after the conference, when 135 of its members agreed that the association should urge all-out support for the conference recommendations. Its members hope, too, to make homemaking teaching and programs more "family centered," and to stimulate more research relating homemaking to child development. The Association for Supervision and Curriculum Development, National Education Association, is giving major consideration to the White House Conference findings and recommendations at its annual meeting in February. In March the directors of nursing in State departments of health at their biennial meeting with the Public Health Service and the Children's Bureau will consider the implications of the White House Conference for nursing.

Again, these are only early flashes on the way national organizations intend to push ahead. The advisory council on the participation of national organizations "favors a united forward movement to reap the harvest that this conference will produce," reported its chairman, Robert E. Bondy, Director of the National Social Welfare Assembly, at the conference. As evidence of its interest and good faith, this council, with 464 member organizations, voted at its last meeting before the conference to continue as an advisory body after the conference, and to convene again in a year to report on results of follow-up activities. In addition, member organizations agreed to do whatever they can to make the conference findings and recommendations widely known.

Federal agencies that had helped in conference preparations through an advisory council on Federal participation are already spreading news about the conference. Through the Department of Agriculture, State and county extension workers and young people cooperating in extension programs held a 6-day postconference meeting to decide what special significance conference recommendations have for boys and girls in rural areas. Regional medical and child-welfare representatives of the Children's Bureau, the Bureau of Public Assistance, and the Office of Education, are discussing how they can best cooperate in the ongoing projects.

Tying all these activities and interests together will be the national committee, as planned by the final plenary session of the conference. This committee will have some 40 members, including 5 representatives from each of three of the advisory councils and a number from the conference national committee; and the remainder are to be chosen at large. State and local action representatives have already been elected. The Federal Government will continue its cooperation through the Interdepartmental Committee on Children and Youth.

On the evening after the conference, the national committee met to discharge its responsibility on follow-up. It authorized its executive director to turn over to the follow-up committee, after bills are paid, whatever funds there were—and there are funds with which to get started. It approved the appointment of a small staff for the interim period. The national committee is now being organized.

New participants welcome

With these fine beginnings, the real work of the conference gets under way across the Nation, with a spirit and high resolve that promise much for our 53 million children. Citizens who were not a part of the preparatory stage or of the conference meetings but who would like to share in this, its third and most challenging stage, are urged to write to their State White House Conference committees or the Midcentury White House Conference, Federal Security Building, Washington, D.C.

PLEDGE TO CHILDREN

TO YOU, our children, who hold within you our most cherished hopes, we the members of the Midcentury White House Conference on Children and Youth, relying on your full response, make this pledge:

> From your earliest infancy we give you our love, so that you may grow with trust in yourself and in others.
>
> We will recognize your worth as a person and we will help you to strengthen your sense of belonging.
>
> We will respect your right to be yourself and at the same time help you to understand the rights of others, so that you may experience cooperative living.

> We will help you to develop initiative and imagination, so that you may have the opportunity freely to create.

> We will encourage your curiosity and your pride in workmanship, so that you may have the satisfaction that comes from achievement.
>
> We will provide the conditions for wholesome play that will add to your learning, to your social experience, and to your happiness.
>
> We will illustrate by precept and example the value of integrity and the importance of moral courage.
>
> We will encourage you always to seek the truth.
>
> We will provide you with all opportunities possible to develop your own faith in God.
>
> We will open the way for you to enjoy the arts and to use them for deepening your understanding of life.

> We will work to rid ourselves of prejudice and discrimination, so that together we may achieve a truly democratic society.
>
> We will work to lift the standard of living and to improve our economic practices, so that you may have the material basis for a full life.
>
> We will provide you with rewarding educational opportunities, so that you may develop your talents and contribute to a better world.

> We will protect you against exploitation and undue hazards and help you grow in health and strength.
>
> We will work to conserve and improve family life and, as needed, to provide foster care according to your inherent rights.
>
> We will intensify our search for new knowledge in order to guide you more effectively as you develop your potentialities.

> As you grow from child to youth to adult, establishing a family life of your own and accepting larger social responsibilities, we will work with you to improve conditions for all children and youth.

SO MAY YOU grow in joy, in faith in God and in man, and in those qualities of vision and of the spirit that will sustain us all and give us new hope for the future.

Aware that these promises to you cannot be fully met in a world at war, we ask you to join us in a firm dedication to the building of a world society based on freedom, justice, and mutual respect.

THE CHILD

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Pledge to Children **119**

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Our readers are asking—

about Midcentury Conference materials—which ones can be had now, and how soon others will be available.

As we go to press, this is the situation:

The Chart Book is for sale now, at $1 a copy. It offers 75 charts in color, on such subjects as child population, housing, infant mortality, child-health services, working mothers, children away from home, babies born out of wedlock, employment of children and youth, and education. Each chart is accompanied by brief supplementary text. Send check or money order for $1 to the Midcentury White House Conference, Washington 25, D. C.

The conference has had mimeographed a list of educational films. (This listing does not imply endorsement by the conference). All are 16-mm. films; all have sound. Time required and distributor are given for each, as well as a short description of the picture. This list is free.

The conference has added another record (two sides) to the album that we described last month. Besides the excerpts from the major speeches, the album now includes a 27-minute documentary program, which gives a running account of events at the conference from the opening day to the debate by the delegates on the conference recomfendations. The set includes seven 16-inch double-faced records, 33 1-3 rpm. They can be played on any standard playback equipment, but not on the ordinary home record player. Price $10. Pay in advance or on delivery. Write to the Midcentury White House Conference on Children and Youth, Washington, 25, D. C.

The conference proceedings are expected to come from the press in April. The complete fact-finding report, however, will not be published until fall.

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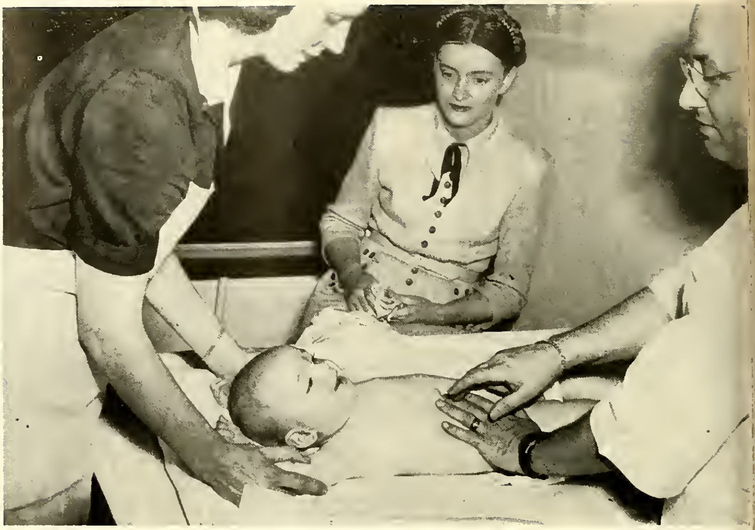

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CHILDREN CAN BE HELPED TO FACE SURGERY

RUTH M. PILLSBURY, M. D.

A PHYSICIAN knows well that a surgical operation is a major event in a child's life, which may or may not have a marked effect upon his developing personality.

What will be the effect of the surgery on the child's attitudes? Will he return home from the hospital with faith in the kindliness of the adult world which will give him confidence in meeting the problems of his life as they arise? Or will he be distrustful of adult motives and behavior, fearful of doctors, hospitals, white gowns, and possibly of strange situations in general? These are questions which we can no longer slough off lightly as being outside the field of medical practice.

We do the child little good by remedying a physical condition if at the same time we create new problems or intensify existing ones, whether these problems be physical or emotional.

What can the busy doctor do to fulfill this added demand upon him for psychologic guidance? He is not a psychiatrist, nor is psychiatric care ordinarily indicated, any more than a neurosurgeon need be consulted every time a youngster bumps his head. Yet it rests with the child's doctor (not the psychiatrist) to be aware of the significance of minor events or of aberrations in behavior which could, if unwisely handled, lead to more serious emotional difficulties.

No matter how kindly and understanding doctors and nurses are, the success of their work with children depends to a great extent upon the nature of the child's relationship with the adults in his world long before the question of surgery arises. A child who is terrified and who has not learned to trust adults, or perhaps who has learned *not* to trust adults, cannot be won over in the short time between entering the hospital and being given the anesthetic.

If we expect a child to have faith in adults it is vital that adults keep faith with him. Has mother told him that he is going to the store for an ice-cream cone, and instead he has found himself in the doctor's office awaiting a "shot"? Next time mother suggests a trip to the store he will be suspicious. Or has the doctor said, "This won't hurt," and then proceeded to jab him with a hypodermic needle? Such a child will never again believe the reassurance, "This won't hurt."

The child can feel that the doctor is his friend, a person he can trust, a person who likes and understands him. Even if painful things have to be done, the child can sense that the doctor always keeps his word, that he hurts no more than necessary, and that he really likes him. For a

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doctor to scold a frightened or recalcitrant child for expressing his natural feelings will soon convince him that the doctor neither likes him nor respects how he feels.

Mother's attitude toward the doctor is also important. If she has handled the visits to the physician in a friendly and matter-of-fact way, the child has a chance to learn to respond in kind. If she is unduly anxious, the child will sense this and reflect her anxiety. If she has held the doctor over the child's head as the authority who makes him eat his spinach, or has threatened him with a visit to the doctor if he misbehaves, the doctor will have a difficult time winning his confidence.

The physician's responsibility in preparing the child for surgery, therefore, does not begin when surgery is first contemplated, but rather with his first contact with mother and child. This applies not only to the doctor's personal relationship with the child but to his guidance of the mother-child relationship. Anything which he can do to aid this relationship is not only good practice of mental hygiene but is time well spent for the doctor, often leading to less hectic afternoons in the office with frightened children and exasperated mothers.

Here the busy doctor is of necessity an opportunist, capitalizing on the samples of behavior which are exhibited during his contact with the child, both to aid the child and to further the mother's understanding of his behavior. A sympathetic ear for the mother, allowing her to discuss what she considers her problems even though they may not seem problems to the doctor, may do much to save him from frantic telephone calls when minor problems have become major ones and mother has reached the bursting point.

Tactics vary with circumstances

In the case of the acute emergency, such as a rupturing appendix or a fractured leg, it is too late for psychologic guidance, and all the pediatrician can do is to fall back upon the child's previous relationship to him and to the other adults who have so far been part of his world, and do what needs to be done as quickly and gently as possible.

One disturbance at a time

The timing of nonemergency surgery is often of great importance in its effect on the child. In general, surgery should not be contemplated when a child is going through a period of particular stress. The most common contraindication on psychologic grounds, which is often missed because a child may not show overt signs of disturbance, occurs in the 3 months before and the 6 months after the birth of another child in the family. This is naturally a time of upset for any youngster.

There is another reason why this is not a good time for hospitalization, at least for preschool children. The ages of 3 to 5 or 6 are the ages when the child takes great interest in where babies come from, and this interest is accentuated by the arrival of a baby brother or sister. Too many parents dodge explanation by telling children that babies come from hospitals, and this complicates the child's feelings toward his own hospitalization.

Physical vs. emotional needs

A case in point was a 5-year-old boy who underwent a tonsillectomy when his baby brother was 3 months old. He had been told that babies come from hospitals and had seen his mother go to the hospital and return home with the new baby, obviously weaker than when she left.

He took the operation well and seemed happy in the hospital, spending most of the time cooing at a small baby in the next crib. When the time came to go home, he screamed, kicked, and fought, and it was some time before he could be quieted enough so that his parents could find out what was bothering him. He thought the baby next to him was his own baby and that he was being deprived of it! Explanations did little good, and for several months he would go up to any mother with a small infant and attempt to take him away from her. This child grieved as much as if he actually had had a baby which he had lost. While this story may make amusing telling in a medical meeting, it was a real emotional trauma for the child.

As part of preparation for hospitalization at this crucial age, the physician may find out from parents what information the child has been given as to the "facts of life" and help the parents to get this straightened out before recommending hospitalization.

It is poor timing to try to remedy a child's physical condition at a period when there is likelihood of creating or increasing emotional disturbance. In some instances it may be wise, for example, to postpone surgery for a few months, perhaps at the expense of a few extra attacks of tonsillitis, until the child is deemed emotionally ready.

Now, for example, suppose we have an ordinary, well-adjusted baby 8 or 9 months old, who has a friendly relationship with his doctor and needs to have his tonsils out. What should we do to make the hospital problem easy for him?

If he is too young to have the situation explained to him in words, little can be done in direct preparation, yet there are still things we can do to help him. Since the hospitalization itself will be a problem for him, and one problem at a time is enough for anyone, it is wise to keep from piling demands on him.

It may be possible to avoid any changes in his usual routine which might be disturbing to him. One change that can be postponed is weaning. He may be able to handle either the hospitalization or weaning, but both might be too much for him.

The pediatrician may discuss with the mother the inadvisability of going ahead with other matters, such as toilet training, a new crib, a family trip, and so on, until the child has had a chance to settle down from the experience of surgery.

Being away from home and mother is one of the most disturbing elements of hospitalization to a young child. For the child who has never been away from his mother this is doubly difficult. We can help him to accept the separation by beginning gradually, ahead of time, under less distressing circumstances. Getting him used to a baby-sitter for increasing periods of time, and later getting him used to staying at a friend's house while mother goes shopping—such experiences, though he may dislike them at first, will give him reassurance that although mother sometimes leaves him, she always comes back. Conversely, the practice of sneaking out when the child is asleep and letting him awake to find his mother gone, although sparing everyone a fuss at leave-taking, will make him more anxious about her whereabouts and thus make hospitalization more difficult. The first separation from mother should not be under the conditions of a hospitalization if this can possibly be avoided.

We must remember that in the absence of the parent whoever handles the child becomes a temporary substitute for that parent and becomes invested with those qualities of the parent which mean security to the child. The person who bridges the gap between home and hospital is frequently the child's own doctor. No child should be subjected to the frightening experience of an anesthetic without the reassuring presence of a familiar face. If his own doctor is not to be present at the operation it may be possible for the child to become acquainted with the surgeon, anesthetist, or nurse ahead of time.

Tell him in good time

For the older child, who can talk, the same principles hold true, but more can be done to prepare him. Preparation literally means just this—advance knowledge of what is going to happen. Fear of the unknown is always worse than fear of the known. Although it is not wise to overemphasize the painful aspects involved, we should give the child some advance indication of the less agreeable side of hospitalization in order to prepare him more fully for what he must face.

Too long a period of preparation gives the child time to build up anxiety. A week is usually sufficient. We have seen instances where overpreparation has led a child to feel that the parent "doth protest too much," and the very anxieties which the parents were trying to allay were thus intensified.

By the time the date for surgery is growing near, the youngster, having had his ever-sensitive radar devices tuned to the world about him, is quite aware that something called "having his tonsils out" is about to happen to him, whether the parents think he knows about it or not. He certainly wonders what it is all about, and he may have even built up some elaborate fantasies on the subject. He now needs to know in simple terms what all this means.

He probably does not know what tonsils are, but he does know what his symptoms have felt like, and so explanations can be approached through his personal experience. The doctor may or may not want to discuss this himself with the child, but in any case he may discuss it with the parents so that they can give the child sound information. The child may be told that he is going to have his throat fixed so that he will not have so many bad colds or earaches or sore throats—whatever his symptoms have been.

If he is older and asks further questions they may be answered in a matter-of-fact manner: or he may even want to look into someone else's throat and see for himself what tonsils are. Whether he asks questions or not, he is wondering, "Just what is it going to be like? Will it hurt?"

One can often arrange a preview of coming events for him, which should be as much a part of the preparation for a tonsillectomy as the laboratory work-up. A trip to the hospital for sightseeing frequently dovetails nicely with the laboratory work. A ride in the elevator can be added, or an inspection, or a ride in a wheel chair.

The procedure can be explained to him, little details in terms he knows: Getting up in the morning; riding to the hospital without breakfast; being undressed and having his temperature taken; the shot (yes, the shot!) to make him more comfortable afterwards; talking to the nurse or doctor who will give him something funny to smell; going to sleep and waking up later with his throat feeling queer and sore; feeling very sleepy and sort of sick for a while; being sleepy all day and all that night and having mother come for him in the morning. These are things he can understand and anticipate without too much anxiety. The knowledge of what to anticipate will make the situation easier for him to face.

Don't mislead him

He need not be frightened by gory details, but neither need he be under the misapprehension that the whole thing will be a gay good time.

Some children will enjoy play-acting ahead of time with the family, going through the procedure in play as preparation for the later experience.

After he comes home he may want to act out his experience in his play with dolls. A present of a "doctor set," available in many toy stores, may help him to master his feelings about the experience, through play.

Children have more ability to face difficult situations than is generally realized. We do not need to feel that early surgery will be of necessity a psychic injury, or that if such injury occurs it will inevitably lead to an emotional handicap. In preparing the child for a surgical procedure the doctor has a signal opportunity not only to prevent such injury, but also to help parent and child toward a better understanding of each other.

By going about it in a matter-of-fact way, neither frightening him nor failing to prepare him by trying to protect him too much and thereby belittling his ability to handle situations, one may help the child to master this situation for himself, thus bringing about in him an increased feeling of confidence in coping with future exigencies of life.

Reprints in about 6 weeks

WHILE MOTHERS WORK AT DEFENSE JOBS

I. Evelyn Smith

PLANNING for services for children of working mothers in the present mobilization period should build on experience during and since World War II, and develop a broader range of services than was available during that period, 36 educators and social workers recommended to the Federal Security Agency, at a meeting at Washington January 16-17. The meeting was called by the Office of Education and the Children's Bureau, both of the Federal Security Agency.

Recommendations of the group were made against the background of information on the present and prospective manpower situation facing the country given to them from the President's Economic Report of January 1951 and by officials of the Department of Labor. "In expanding the labor force," the President had stated in his report, "the most important source is women, especially nonworking married women who do not have the responsibility of caring for young children. Women who work in defense jobs and who have children should be assisted, by means of nursery schools and other child-care and community facilities, to care for their families and their homes."

Many factors, the Department of Labor officials pointed out, make today's manpower situation different from that holding in the 40's.

Ten years ago the Nation faced a relatively short period of preparedness and war, while the present problem is one of partial preparedness for a long time to come.

While the population has increased by 20 million in the last 10 years, we now have a larger proportion of children and of persons 65 and over.

An important difference for day-care planning lies in the fact that a decade ago industrial defense plants were concentrated in certain urban areas; now plans are being made for scattering such plants around the country.

Again, before World War II we had time for planning an all-out war effort, but this time, if war comes, we shall have no time; so we must do our planning in advance.

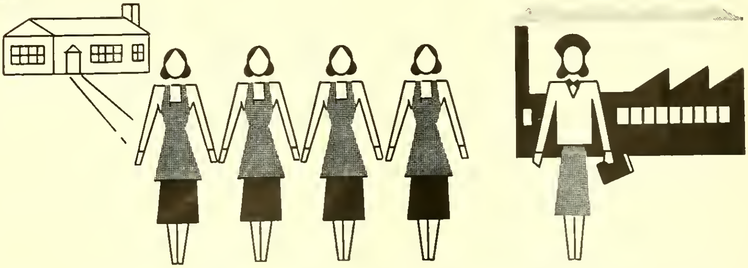
Mobilization in the 40's followed mass unemployment, and unemployment now is at a minimum. Ten years ago the country was looking toward building up an army of 12 million, while present plans call for a standing army of 3½ million. Because of current high employment, emphasis in meeting defense needs will be placed first on shifting the labor force from nonessential to essential jobs. It is not expected, however, that shifts will sufficiently meet manpower needs, and women, especially those 35 years of age and over, will be looked to as the major source of new workers.

Increased employment of women follows a long-time trend, it was pointed out. Whereas 40 years ago women made up 13 percent of the labor force, they now constitute 29 percent. There has been a steady rise in the median age of these workers to 36 years, where it is now. A majority of the women now employed are married, and some 4⅓ million, 25 percent of all employed women, are married, with children. A preponderance of working mothers have children of school age.

Before and during World War II, it was recalled, when many mothers went into defense work, the mothers themselves, as well as many communities, and some industrial firms, tried to provide as best they could for daytime care of the children. When sound community planning was done and adequate services provided, the children's welfare was safeguarded. Many children, however, were not well cared for, especially the younger ones.

In the second year of the war, through a liberal interpretation of the Lanham Act, an act designed primarily to provide for housing in "war-impacted areas," the Federal Works Agency began to allot funds directly to communities for wartime child-care centers. The States had little if any jurisdiction over the plans and operations of these.

At the peak of the Lanham Act program, July 1944, 129,357 children were enrolled, two-thirds of them below school age. Centers were established in every State and Territory, except one, New Mexico, which never applied for funds. During the entire period of the program, August 1942 to March 1946, $51,922,977 of Federal funds was allotted for it—about two-thirds of



One out of five mothers with children under 18 years of age works outside the home

These data, the latest available, are for April 1949. The pictograph is from the Chart Book published recently by the White House Conference on Children and Youth.

the total spent; the rest was made up from local resources, including fees paid by parents.

Since the end of the Lanham Act program, day-care services supported by public funds have decreased each year. California, Washington, and Massachusetts still provide State aid for these services, but they are the only States that do, except that New York helps to support day-care centers for children in camps for migrant laborers. In a few scattered cities, local public funds are available for day care. Voluntary agencies also carry on day-care facilities, and so do private individuals.

To find out the present needs of working mothers in the areas where the manpower problem is greatest, the group recommended that for long-time planning, local and State agencies study the needs and resources of their communities; for a quick review, it was recommended that the Children's Bureau and the Office of Education join in making a quick and simple survey.

Even without these surveys it was clear that the present needs of working mothers are not being fulfilled. Reports from many communities show that what day-care services are in existence are operating up to capacity, with waiting lists, and that pressure for more services has been felt for the past year and a half.

Both public and private agencies trying to provide day care report a shortage of money, of places to establish centers, and of equipment. Few teachers and social workers are available to man such centers, and facilities to train them are inadequate. For children too young to benefit from group care, foster parents are sought, but they are hard to find.

We all need to realize that caring for children is a great service to the Nation, the conference agreed, and credit should be given publicly to the mothers and foster mothers who do this essential work.

Children's welfare comes first

Stress was laid on the fact that a major responsibility of women with young children, in war as in peace, is to maintain the values of family life and to assure their children of security and opportunity.

In order that established family life may not be unnecessarily broken up, the conference recommended that industry defer organized recruiting of women with young children until full use has been made of all other sources of labor supply. At the same time the right of mothers to make their own decisions about taking employment should be respected.

Whenever it does become necessary to employ women with young children these employees should be assigned to such hours as will cause the least disruption in their family life, the conference said; and organized labor and management should be encouraged to plan together for part-time jobs for mothers, with shifts that take account of their home responsibilities.

School children whose mothers are employed need not run the streets before and after school if their community provides extended school services for them at these times.

Also, the recommendations continued, the community should provide adequate facilities for the satisfactory care of children during their mothers' working hours.

In recommending methods of planning for day care of children of employed mothers, the conference urged that all such planning should be focused on the child as a whole, in relation to his family and his community.

Facilities for day care should be community projects, the conference held, and should not be administered by employers.

A well-rounded program of day-care service, the conference agreed, should include not only group care, but "extended school services" (care for school children before and after school hours and at day camps and vacation camps); foster-family day care; health services; homemaker services; and individual counseling service for mothers planning to enter employment and for those already employed who wish to make arrangements for care of their children.

And in order to safeguard the children cared for through these measures, it is essential, according to the recommendations, that standards be developed dealing with con-

(Continued on page 135)

Miss I. Evelyn Smith received her graduate degree in social work from the University of Chicago's School of Social Service Administration. She was on the staff of Chicago's Council of Social Agencies during World War II, and participated in planning for day-care activities. Miss Smith is now consultant on foster care in the Division of Social Services, Children's Bureau. At the meeting reported here she served as consultant to the committe on findings and recommendations. She is a member of the day-care committee of the Child Welfare League of America.

CITIZENS HELP A JUVENILE COURT

Charles H. Boswell

IF THE needs of children coming before a juvenile court are to be met, the court needs the backing of the citizens of the community. We must not forget that courts, like other public agencies, exist to serve the community, and that paid staff members are the employees of those who pay the bills. But too often the doors of courts are closed to interested and well-qualified citizens who want to help us professional workers in our efforts to develop and refine our programs for children and young people.

Of course, it is not just any group of citizens that can be helpful; we need an enlightened and nonpartisan group. And it is necessary that each person asked to participate must himself have a feeling of personal responsibility. He must be moved to action by something within himself; he must have what Quakers call "a concern," or what the military describe as a "call to duty." However, we should remember that, as citizens participate, the feeling of responsibility grows.

Dr. Eduard C. Lindeman has said that: " . . . In a democracy, power must always be tempered, must never become absolute or too highly centralized. Experts and the experiences of the people need to be brought into working harmony; . . . the agencies and institutions which employ skilled personnel must also be brought within the pattern of democracy. This democratizing process can become effective only when technicians march forward to their tasks with citizens at their side. Some professions may be able to produce with a relatively high degree of acceptance without citizen participation, but social work is the one profession which cannot afford to go on alone." (National Conference of Social Work, 1948: Proceedings, p. 85.)

Dr. Lindeman would have us give up the false conception that citizens can help only in private or volunteer agencies. Instead, let us have citizens advise the policy-making branches of public services. I do not mean that citizens will decide cases for the judge or do the work of the probation officer. I do mean that citizens can help the judge and the probation officer to understand the community's needs and can interpret to the community the work of the court and its needs. This two-way action is one of the methods by which democracy keeps itself free from dominance by either officials or technicians.

Not an easy job

It is true that the task of developing strong community participation in court work, which involves all the major community interests and points of view, is one of the most difficult jobs in professional social work today. But the difficulties are no excuse for our not doing the job.

One juvenile court that has opened its doors to interested citizens is the Marion County Juvenile Court, in Indianapolis, Ind. It did this early in 1947, shortly after the present judge took office. The results have been breathtaking, as we have come to realize the citizens' great ability to help us.

Before the election over 600 citizens had formed a committee dedicated to seeing that each major political party nominated a qualified candidate for the juvenile-court judgeship. And the successful candidate, even before he took office, realized that his court would function more successfully if he could have the aid of enlightened citizens interested in the work of the court. He therefore selected 10 leaders from the bipartisan group to serve as the nucleus of a citizens' advisory council.

I want to suggest here that it is not wise to urge a judge to appoint an advisory council if he is opposed to such a plan. The idea of appointing an advisory committee on the ground that it would be theoretically desirable would not inspire anybody with enthusiasm. Better to wait until there is a definite problem that an advisory group might be able to help the court solve. You can easily see that better results will be achieved if the advisory council is organized after the judge feels sure that such a group has something to contribute. And there is no reason why the suggestion concerning an advisory group cannot be made to the judge by the chief probation officer or the person in charge of the social-work program.

Usually the appointment of such a group can be brought about when the judge sees that a certain problem can be solved, or a job done much more efficiently, through enlisting the aid of a citizens' group.

Our judge saw clearly the many problems that he faced in taking over the important post of juvenile-court judge in a large metropolitan district. He did not want to dominate the advisory council, and he worked to help it develop and work in a democratic way. He permitted the nucleus group that he had appointed to add additional members, and the membership has gradually increased from 10 to 50 during the past 3 years. Most of the important elements of our population are now represented, including organized labor; the press; business clubs, such as the chamber of commerce; minority racial and religious groups; women's organizations, such as the League of Women Voters and the Business and Profes-

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sional Women's Clubs; the American Legion; clubs, such as Kiwanis, Optimist, Exchange Club, Masons, and so forth; and the various professions. Certain public officials, such as the head of the juvenile-aid division of the police department and the head of the social-service department of the public schools also are members.

What the council does

If the capacities of the group are to be fully used, ingenuity, leadership, and initiative must be exercised by the court. Of course, the functions of the advisory council are defined by the judge who appoints it. Such functions might include advising on difficult cases; helping to formulate policies; and helping to interpret the program to the public, and the public's ideas to the court. In a sense, the collective opinion of such a group is a poll of public opinion.

In the beginning our advisory council usually expressed itself only about questions on which its opinion was sought. Later, after a period of successful operation, the council began to volunteer suggestions concerning policies, after studying and discussing them.

Our judge wisely delegated to the advisory council the responsibility for selecting personnel to fill the positions of probation officer and referee. No one is appointed to the professional staff whose qualifications have not been studied and approved by the personnel subcommittee of the advisory council. This procedure has relieved the judge from partisan pressures, and also it has rapidly increased the confidence of the public in the judge and the juvenile court.

A by-product of the work of the personnel subcommittee is a scholarship plan. The subcommittee, in its first few months of operation, learned that there was an acute shortage of trained social workers in the State. Therefore the chairman reported to the advisory council that if the members expected the juvenile court to employ trained, qualified social workers a scholarship program was an imperative need. By this time the advisory council had become convinced that probation officers needed to be trained in a graduate school of social work.

The present scholarship plan provides two scholarships annually for promising young college graduates who desire to enter Indiana University's Division of Social Service for 2 years of graduate training. One of the scholarships amounts to $1,200 a year; the other, $800 a year. The student agrees that upon completing his training he will accept employment at the juvenile court for a period equal to the training period financed by the advisory council. To finance the scholarship plan, the council raises funds from private sources; and another subcommittee, known as the scholarship committee, is responsible for the fund raising. As a result of this plan, each year two carefully selected students who have completed graduate social-work training are available to fill the vacancies that occur on the court staff.

Children coming before the Juvenile Court of Marion County, Ind., receive more effective services from the court as a result of the activities of its advisory council of citizens.

Since adequate financing is a question that confronts most courts, a budget subcommittee studied the budget for the court and the detention home (which we call the juvenile center) and found that the budgets were inadequate. After determining the needs of the court and the juvenile center, the budget committee sat down with the judge to draw up adequate budgets. This preparation was only the first step. Budget-committee members took the budgets to taxpayers' organizations, to managing editors of newspapers, and to other interested organizations, for the purpose of obtaining their approval of the new requests and backing for them. Their success is evidenced in this quotation from an editorial that appeared in Indianapolis' largest daily:

"Doubtless there are many governmental agencies whose budgets could be cut at a considerable saving to taxpayers, but the juvenile court is not one of them. The best argument for approval of the budget is the fact that it has been approved by the juvenile-court advisory council, a group of responsible Marion County citizens. As taxpayers, naturally none of them is eager to see a budget increase. But as citizens and parents they know that a few dollars spent now may save the future of a child, as well as preventing the incalculable cost of dealing with him, and many others, as adult offenders."

Another Indianapolis daily, the morning paper with the largest circulation in Indiana, said:

"How much is it worth to the people of Marion County to turn our problem children into mature and useful citizens? How much is it worth to keep our juvenile delinquents out of jail, to help them become adjusted to community life? The Marion County appropriating body is being asked this question through the request made by the juvenile court for an additional $3,200 to improve the probation services of the court. We can't afford to cut corners in the prevention and correction of juvenile crime. Delinquency has increased steadily during the past year. To meet the challenge and the responsibility that these misled and potentially dangerous youngsters present, we must have people of outstanding ability, character, and enthusiasm.

It is no easy job to lead a young boy or girl back on the right path once they start on a career of crime or self-degradation.

"Sympathy, understanding, and patience are needed. Only devoted, contented, and trained probation officers can do this job for us. The Marion County Juvenile Court is not asking for the impossible. It is asking for the means to reclaim hundreds of our young people who might otherwise become menaces to society. Their budget request should be granted by the appropriating body."

Since the advisory council was formed, every budget submitted by the judge of the juvenile court has received editorial support from the large Indianapolis dailies and has met no opposition from the taxpayers' organizations.

From our experience in Indianapolis, I suggest this if you are having what appear to be insoluble budgetary problems, try working with a citizens' advisory council in solving them.

Did the subcommittee "pass a miracle"?

Another subcommittee has worked to improve the physical facilities at our juvenile center. No major repairs had been made for 5 years before the advisory council was formed. The roof was a sieve, the plumbing fixtures leaked, many of the floors had rotted away, the plastering had crumbled, the security screens had rusted and deteriorated so much that they were useless, and the heating system seemed to operate only during the warm months. The subcommittee proceeded to "build a fire" where it would do the most good—under the county officials responsible for this neglect of county property. Civic organizations were told the story, newspapers cried out in protest, and then action resulted. All urgent repairs were finally made, as a result of the interest stimulated by the council.

Improvement of the physical facilities at the juvenile center has not been the only project of this subcommittee. It has arranged for assignment of a public-school teacher—a carefully selected woman—for the center. Volunteers skilled in the teaching of arts and crafts have been engaged to help the paid staff member who is responsible for this program. And hundreds of dollars worth of materials have been procured by this same subcommittee. The juvenile center has become almost the personal property of this subcommittee, and their concern for it is the same kind of concern they have for their own living quarters. Again I want to reiterate that there is no substitute for citizens' interest and participation if you want social action of the right kind.

I shall not attempt to describe in detail all the achievements of our advisory council during its first 3 years of operation. However, I want to mention briefly two other attainments. Through funds obtained from private sources the advisory council was able to employ for the first 6 months of the present judge's administration the services of an outstanding consultant, a professor on the staff of Indiana University. This man has had wide experience as a probation officer, as a classification officer in a correctional institution, and as a teacher in a graduate school of social work. His advice and counsel were extremely useful in helping the judge to organize his court.

The advisory council also appointed the inevitable publicity committee. Although the council was never told in so many words that one of its jobs was to interpret the program to the community, nevertheless the judge and the members of his staff hoped that the advisory council would be able to allay any unfair criticism that might arise in the community and would promote sympathetic understanding of the court's work. I do not want to imply that the members of the advisory council spend a large part of each day telling their fellow citizens about the juvenile court and the unmet needs they have discovered. However, they have been successful in telling our story where the telling is most effective. Furthermore, the members have come to be regarded as responsible sources of information about the program and about the needs, not only of the juvenile court, but also of closely allied agencies.

Council stimulates council members

As to interpretation, we have found it wise to follow the lead of one experienced executive who said, "I don't spend time trying to interpret to the board; I just try to put them to work." Keeping up the interest of the advisory council and keeping the members at work is no easy matter. Considerable thought, planning, and time are necessary to make the meetings of the citizens' group meaningful. Each meeting provides opportunities for the members to participate in some way, discussing a problem or a policy, or making a committee report, or asking questions about cases or the court's program. Nothing would dampen the enthusiasm of such a group so much as attending a meeting which appeared to them to serve no particular purpose. Active participation assures their continuing interest.

A successful advisory group deserves and should be given recognition for its contribution. Our judge takes particular care in giving credit wherever possible to the council. It is not undeserved praise that he gives, but a merited and grateful recognition of the faithful service the members have given the community in strengthening the program of the juvenile court.

In summary, these are the salient accomplishments of the advisory council to the Marion County Juvenile Court: Help in interpreting its program to the public; in formulating its policies; in engaging competent personnel; in raising the standards of service; in obtaining adequate office space and supplies; in developing special programs, such as arts and crafts, at the juvenile detention center; in improving the court's relations with other agencies; in securing adequate budgets for both the court and the juvenile center; in securing adequate salaries for employees.

Reprints in about 6 weeks.

TOWARD THE FUTURE

15 years of progress in maternal and child health

Edwin F. Daily, M.D.

AS WE look back over the more than 15 years since the Social Security Act was passed, we find that tremendous progress has been made in maternal and child health.

Maternal mortality for the Nation has decreased over 80 percent, and many States now have less than 1 maternal death for every 1,000 live births.

Infant mortality is down nearly 45 percent, and few of the infant deaths occur after the first weeks of life. Over 85 percent of deliveries now take place in hospitals, as contrasted with much less than half of them 15 years ago.

In some fields we have advanced more slowly than in others, and the death rates for Negro mothers and children are still much higher than those for white.

Medical knowledge and the skills of health personnel have improved amazingly. Parents' knowledge of health is appreciably greater than it was 15 years ago. And communicable diseases among children are far less serious now.

Among the important scientific advances that have modified health programs for children are: Discovery of the sulfa drugs, penicillin, and other antibiotics; use of blood and blood derivatives; perfecting of pertussis vaccine; application of fluorides for prevention of tooth decay; use of the electroencephalograph for diagnosis of epilepsy, and of new drugs for control of this disease; discarding of immobilization of affected limbs of polio patients in favor of early mobilization of such limbs and the use of hot packs and drugs for relaxation; use of new methods for early detection and treatment of hearing loss in children; amazing improvements in the care of prematures; and new knowledge of the importance of proper nutrition in pregnancy and childhood.

Perhaps the most important advance is that we know more about how emotional attitudes play a part in determining the course of illness or of pregnancy or of a physical handicap, and in the effectiveness of treatment. And we know that, on the other hand, such conditions affect the emotional health of mothers and children. We know now that understanding the feelings and attitudes of people is as essential as providing immunization, diagnosis, or treatment. We are learning that if health workers are to succeed in improving the health of a child, they must understand the social, economic, and environmental factors that affect the whole family.

Ten to fifteen years ago no one subject received more attention in maternal and child-health programs than child-health conferences. Thousands of such conferences were developed; and far too many became merely a place where immunizations were provided, the children weighed, and a few recommendations made about diet.

Today we feel that a child needs much more than that, and that every parent, doctor, nurse, teacher, and other person influencing the life of a child should have better knowledge about the mental, emotional, and physical growth of children, so that they may help and not hinder the child in his struggle toward maturity.

Intimately related to the growing understanding of the individual mother and child is the recent trend toward "humanizing" hospital care for both mothers and children. Some hospitals now *do* try to see that clinic patients are not herded like sheep, that their hospital stay is a pleasant experience, and that a child is comforted by friendly concern about him on the part of the doctors and nurses. More consideration is given to the wishes and requests (or whims, if you will) of the patient. The closely-packed nursery with its separation of mother and child is gradually disappearing as it is replaced by the warm and satisfying experience most mothers and babies have with rooming-in.

For the child with a long illness

Particular attention is now given to the emotional, recreational, and educational needs of the child who is in a hospital or convalescent home for many weeks or months at a time.

A few communities have learned that many children who are ill for a long time can be cared for better in their own homes, with home services by all professional workers needed, and at far less cost than in a hospital.

Today we are trying to help plan the most important things to do as these health services for mothers and children are expanded. This fiscal year the combined Federal maternal and child-health and crippled children's funds and required State matching funds amount to $34,762,500, more than three times what they were 15 years ago.

Although the Congress and the States recognize to this extent the importance of children's health, I wonder if there is any clear-cut idea

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Dr. Edwin F. Daily, as Director of the Division of Health Services, Children's Bureau, administers the Federal grants in aid for maternal and child-health and crippled children's services under the Social Security Act. Dr. Daily acted as an expert consultant to the WHO in 1949 and 1950. He was a U. S. delegate to the Fifth and Sixth Decennial Commissions on Revision of the International List of Diseases and Causes of Death, Paris, 1938 and 1948, and is a member of the United States Committee on Vital and Health Statistics. He is also a diplomate and consultant, American Board of Preventive Medicine and Public Health and a diplomate of the American Board of Obstetrics and Gynecology.

This article is based on remarks made by Dr. Daily at Children's Bureau regional meetings with State maternal and child-health and crippled children's agencies, at Atlanta, Chicago, New York, and Denver.

about the health program for children in the minds of parents.

Wherever I go, I am asked the question: What is this maternal and child-health program? Although people clearly understand the public program for education of children, and the great programs for the control of venereal disease and tuberculosis, and, to some extent, the crippled children's services, they don't seem to know much about the health program for mothers and children.

Can't we make clearer what we are striving for in the maternal and child-health and crippled children's programs by dramatizing it for the people in every city, town, and country village in the Nation? Shouldn't every family in America know what local health departments and crippled children's agencies are aiming at, what they plan to do for children this year, and what they hope to do next year?

In these programs, as with others, there can never be a Nationwide plan, nor 53 plans that are uniform throughout the States and Territories. But there can be a plan for each community that is the citizens' own plan. They must help make it, must be intimately concerned with its success or failure. Citizens must be willing to volunteer so as to make it a success. And if there is good local planning, State and National agencies can do their part much better. I have yet to learn of any program that remained successful over a period of years without active citizen cooperation.

Some local health councils truly represent citizens' interest in children; most of the local parent-teacher associations are deeply concerned about children's health; many special groups are concerned with one phase or another of child-health work. And a thousand *local* White House Conference committees, interested in the problems and needs of children, make up one of the most potentially influential groups in the Nation. But the energy and strength of groups of parents is largely untapped. Here is an opportunity for groups of citizens in every village and town, and every section of every city, to consider thoughtfully what *they* think are the health needs of their children.

Citizen or parent groups, however, cannot do their best without guidance. In deciding what should be done for their children they need to find out from those of us with professional knowledge what we believe is possible, and what is most desirable. They need to be clear about what their own local health problems are, and to what extent the community is using the resources available. And they need to know what other communities are doing. Once these groups have basic knowledge of their community, the inevitable question is: What is the best thing for us to do this year, and next year, with the dollars we have available? I shall list only a few of the possible questions that might face a community with limited resources:

Mothers—and fathers too— know more about health than they did in the past. And teaching sessions like this one at a maternity clinic have done much to help them learn.

Shall we give *every* child in our community the benefit of topical application of fluorides by dental hygienists and thus prevent 40 percent of childhood dental decay? Or shall the dental hygienists' time be used for inspections of teeth and lectures on dental health?

Shall we provide prenatal care for the mothers not now receiving it? Or, for the same money, shall we provide hospital care for a few of them who develop serious complications?

Shall child-health conferences be provided if they are not now available in the county? Or shall we establish child-guidance clinics?

Shall we give more postgraduate training in pediatric or maternity nursing for selected nurses in our hospitals and our health department? Or shall we employ more public-health nurses for our understaffed general public-health program?

Shall a center for the care of prematurely born infants be established in our community? Or shall studies be made on why such a large proportion of the premature births seem to occur among the mothers living in one area?

Shall we provide routine medical inspections of all our school children? Or shall we provide for better screening devices to be used by teachers, technicians, and nurses, who will refer the children needing special care to pediatric diagnostic and treatment services?

When there is an opportunity to enlarge the scope of the crippled children's program in the community, shall we give priority to children with cerebral palsy, or with rheumatic fever, or with epilepsy, or with other conditions?

Shall we provide better health services for the children in detention homes, in homes for neglected children, and in other institutions? Or shall we provide better physical examinations for the school athletic teams?

Shall we work for construction of a convalescent home for children, or for more pediatric beds in our general hospital?

These and hundreds of other questions confront most communities today. They are not easy for any community to answer, nor for any of us to answer, without a great deal of thought and study.

When we are asked to help answer these difficult questions, we are often handicapped by lack of facts. Many of the greatest gaps in our knowledge are due to the fact that few critical studies have been made of the value of many phases of present child-health work.

Some of these gaps are suggested in the following questions:

How important to the health of an expectant mother is a home visit by a nurse who has not a sound basic knowledge of maternity care?

What evidence have we that pamphlets and talks on dental health have improved the health of children's teeth?

What methods of nutrition education are most effective in improving families' dietary habits or child-feeding practices?

To what extent is the health of children in a county that is served by a rheumatic-fever program better than the health of those in the next county where there is no such program?

In addition to the need for such critical program evaluation, there is a great need for further data. How can we plan ahead without knowing the approximate cost of each service and what a given amount of expenditure may mean in partly or fully restoring the health of a child? For example: What is the average cost per child for a comprehensive program of service for children with cerebral palsy, or rheumatic fever, or epilepsy; or for premature babies, or for the hard-of-hearing?

Certain other types of studies are also needed.

One such type concerns saving fetal life. For the past 25 years intensive case-by-case studies of the preventable factors in maternal and infant death have produced information of the greatest value in planning measures to reduce such deaths. The loss of life before birth is now known to be far greater than was suspected a few years ago. Case studies of fetal and neonatal deaths by groups of physicians working in cooperation with health departments and hospitals are likely to produce equally valuable information and lead to measures that would reduce such deaths. The relation between poor nutrition and fetal wastage especially needs further study.

Additional studies of premature births are needed, to determine, if possible, the measures that are most likely to reduce the incidence of prematurity. Many of us have qualms about the sizable expenditures of maternal and child-health funds for the care of premature babies, without more emphasis at the same time on improving prenatal care and on other measures that might prevent some of the premature deliveries.

Qualified staff essential

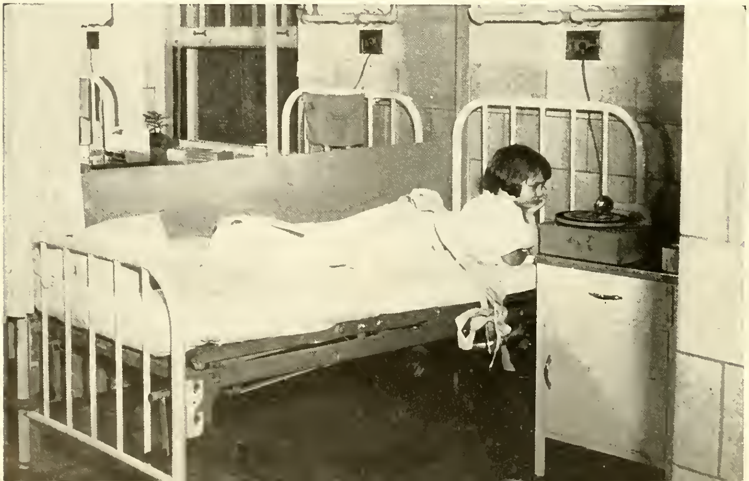
Where we are going in the maternal and child-health and crippled children's programs will depend to a considerable extent upon whether State agencies employ thoroughly qualified professional staff, staff with zeal to do something for the children in their State and with a desire for a career they can look back upon with the pleasure of accomplishment. Such fine workers should be paid salaries truly commensurate with their ability, and should have freedom to use their skills, and should be given sufficient administrative help to relieve them of duties not requiring their professional knowledge. These two child-health programs, which carry so great a share of the responsibility for the future health of the Nation, require career teams of leaders in the medical, dental, nursing, nutrition, medical social, physical therapy, and other professions.

Back in 1936, when the maternal and child-health and crippled children's provisions of the Social Security Act went into operation, even the most optimistic of the workers charged with carrying out those provisions dared not hope for the benefits that mothers and children have gained during those years. For one thing, we had not realized how much citizen groups could help.

Now we look to the future. What does it hold for the mental and physical health of mothers and children?

Reprints in about 6 weeks.

Music is helping this little girl to feel happier during her hospital stay. We now realize better how much a patient's feelings and attitudes can affect successful treatment.



TO GIVE MORE RURAL CHILDREN A CHANCE TO ATTEND SCHOOL

Louise Q. Blodgett

ACTING on the conviction that every child in the United States, rural as well as urban, should be assured a chance to attend school, 31 national voluntary organizations have joined with the United States Department of Labor and several other Federal agencies in sponsoring and distributing an illustrated bulletin, Help Get Children Into School and Out of Farm Jobs During School Hours—United States Department of Labor Bulletin No. 128. 1950. (For the names of the sponsoring organizations and agencies see p. 134.) The special need for increased effort to get many rural children into school has arisen in view of the recent amendments to the child-labor provisions of the Fair Labor Standards Act of 1938, which went into effect January 1950, making it illegal to employ children under 16 during school hours on commercial farms whose products go into interstate commerce.

In many rural areas children are excused from school attendance during crop seasons; and many, because they are employed on farms, drop out of school before they are 16 years of age. Children of migrant farm workers often get very little schooling, either in their home communities or in the areas to which their families go temporarily for farm work. Irregular school attendance makes it difficult for boys and girls to keep up with their classes and encourages dropping out entirely at an early age. School-attendance records show that the average school attendance in rural areas is below that in urban areas.

Of course, the first step toward giving these boys and girls an opportunity for education is to take them out of the fields through enforcing the law, and this is the responsibility of the United States Department of Labor. But even if the Department could immediately investigate all the commercial farms in the country and see that children were no longer employed on them during school hours, this would not mean that the children would thereupon attend school.

In fact, important steps will have to be taken before many of these boys and girls can be offered the opportunity to get an education.

For example, many rural schools, short of funds and of teachers, will need to expand their facilities with the help of community resources. Some of these rural schools will find it necessary also to adapt their courses of study to the needs of the new pupils, many of whom will be found to be very much retarded.

Many children will not be permitted to enter school until they have been vaccinated or have received other health services.

Some will not have the clothes usually considered suitable for school wear; some may not be welcomed by pupils or teachers for personal and social reasons.

Again, transportation will have to be provided between school and farm-labor camps and other remote housing areas before some of the children of migratory families can go to school.

help get children
into school . . .
and out of farm jobs
during school hours
Bulletin No. 128
UNITED STATES DEPARTMENT OF LABOR

These are some of the many steps that must be taken before these rural children, now released by the new law from the jobs that kept them from any possibility of going to school, can begin to get the education that is their right.

It is obvious that the children themselves, and their parents, cannot do much toward taking these steps—that the responsibility for this kind of action belongs to the communities where the children and their families are living.

In order to help the people of the rural communities fulfill this responsibility, the Department of Labor's bulletin here described suggests various methods of spreading understanding of the law.

It urges farmers, educators, school boards and trustees, parent-teacher groups, church leaders, and citizen groups to talk with their neighbors about the new protection for children in agriculture.

It suggests that editors and writ-

Louise Q. Blodgett, formerly a member of the Children's Bureau staff, is now with the Bureau of Labor Standards, United States Department of Labor. Mrs. Blodgett has been Executive Secretary of the Consumers' League of Rhode Island; she has also been Chief of the Division of Women and Children, of the Rhode Island State Department of Labor.

The bulletin described here, How to Get Children Into School and Out of Jobs During School Hours, Child-Labor Bulletin No. 102, is available free for use by State and local groups on request. Write to the Bureau of Labor Standards, U. S. Department of Labor, Washington 25, D. C.

ers headline the law in their local newspapers at crop peaks.

It asks teachers to have children study the law as part of their regular class work.

And it urges everybody to help parents realize that schooling means a better future for their children.

As a step toward preventing illegal child labor during school hours, the bulletin advises farmers, labor contractors, and recruiters not to recruit, hire, or allow children under 16 to work during school hours. And it reminds these groups of the age certificates necessary for older boys and girls who want jobs during school hours.

In order to get the schools ready for the new pupils, the bulletin urges school boards and officials and citizens' groups to work for expanded school facilities when this is necessary to take care of all the children in the community, including migrants; also to provide services such as transportation and hot lunches for the newly arrived children, along with others. Teachers and pupils and the rest of the community, the bulletin says, should be good neighbors to the new pupils and make them feel welcome.

School officials, doctors, and health officers also have a duty to the children. Their duty is to provide inoculation and other health services to get children ready for admittance to school.

To parent-teacher, welfare, church, and service groups, the bulletin says:

"Make newcomers and migrants welcome at church services and activities.

"Provide school clothes and extra health and welfare services for children who need them.

"Provide child-care programs. See that school-age children do not have to stay home to care for younger brothers and sisters during school hours.

"Include migrants in recreation programs.

"Acquaint parents with local ways of getting children into school and with the community's interest in helping their children."

Several printings necessary

The first edition of 100,000 copies of Help Get Children Into School and Out of Farm Jobs During School Hours quickly melted away, and a second and third printing were necessary.

Orders for additional copies indicate that the bulletin is being widely used by county superintendents of schools, principals, visiting teachers, and classroom teachers; by Federal and State labor-law administrators and State and local employment-service officials; by State White House Conference committees; by religious groups; by labor unions and other organizations that promote the welfare of workers: by public health and welfare officials and private health and welfare groups; by the press; and by libraries.

Other uses of the pamphlet are: By university classes in rural life, education, counseling, and labor legislation; by extension courses for labor unions; by Indian schools; by the International Labor Organization; and by labor offices in foreign countries.

Companion bulletin issued

This educational effort, led by the Bureau of Labor Standards of the Department of Labor, has been accompanied by a program carried out by the Wage and Hour and Public Contracts Divisions, advising farm employers of their obligations under the amended law and investigating for compliance with the law's requirement of a 16-year minimum age for employment during school hours. These divisions have issued a companion bulletin, What Farmers Who Hire Workers Should Know About the Child-Labor Provisions of the Federal Fair Labor Standards Act (Child Labor Bulletin No. 102).

It is too early to judge the effect of these projects on the employment of children in agriculture during school hours this year. However, it would appear as a result of the interest of national organizations and Federal agencies in the development of this project, by the demand for the bulletin, and by the interest aroused by the investigations of the Wage and Hour and Public Contracts Divisions, that already somewhat fewer children are being employed in agriculture than were employed last year. Next year should bring results of which the Nation can be proud in getting children into school and out of farm jobs during school hours.

Help Get Children Into School and Out of Farm Jobs During School Hours (Bulletin No. 128) is issued by the Bureau of Labor Standards and the Wage and Hour and Public Contract Divisions of the United States Department of Labor. The bulletin was prepared in cooperation with the Office of Education and the Children's Bureau, both of the Federal Security Agency; the United States Department of Agriculture; and the United States Employment Service of the Department of Labor. The cooperating voluntary national organizations are:

Alliance for Guidance of Rural Youth.
American Association of University Women.
American Federation of Labor.
American Friends Service Committee.
American Teachers Association.
Board of Christian Education, Presbyterian Church in the U. S. A.
Congress of Industrial Organizations.
Council for Social Action, Congregational Christian Churches.
Council on Christian Social Progress, American Baptist Convention.
Department of Rural Education, National Education Association.
Division of Welfare, National Lutheran Conference.
Federal Council of Churches.
Home Missions Council of North America.
National Association for the Advancement of Colored People.
National Association of County and Rural Area Superintendents.
National Board, Young Women's Christian Association.
National Catholic Educational Association.
National Catholic Rural Life Conference.
National Child Labor Committee.
National Congress of Colored Parents and Teachers.
National Congress of Parents and Teachers.
National Consumers League.
National Council of Chief State School Officers.
National Council on Agricultural Life and Labor.
National Farm Labor Union, A. F. of L.
National Farmers Union.
National League to Promote School Attendance.
National School Boards Association.
Social Service Commission, Southern Baptist Convention.
United Council of Church Women.
Women's Division of Christian Service, Methodist Church.

DAY CARE

(Continued from page 126)

struction of the facilities; the equipment; the number and qualifications of personnel; the requirements for adequate health, educational, and social services; and the fees.

Day-care services should be open to all children who need them, without regard to race, creed, or nationality, the group stated.

It was the consensus that no new Federal or local governmental agencies should be established to provide for day-care services; instead, present health, welfare, and education agencies should be assigned this work, and financial resources should be made available through them. It was further urged that governmental agencies, voluntary organizations, and individuals take part in planning for and supplying day-care services.

The conference recommended that any Federal funds appropriated for day-care services carried out by school systems be administered by the Office of Education; and that any such funds for services carried out by welfare departments be administered by the Children's Bureau; also that such funds be channeled through State education and welfare agencies rather than directly to local communities as they were under the Lanham Act.

All day-care programs should be conducted in accordance with standards that assure the safety and well-being of children, the conference stated. Adequate supervision and in-service training should be given workers, and they should be paid salaries comparable to prevailing salaries for similar services. Appropriate equipment should be assured. Such programs will obviously call for increased financial support.

Offering its recommendations on day care of children of employed mothers, the conference urged that in all such planning the child receive first consideration, and stated that "In our democracy, engaged in a prolonged defense of our freedom, the full mental, physical, and emotional development of our children and youth holds high priority in the Nation's security effort."

• IN THE NEWS

Death Rates Decrease Since 1940

Fewer children and young people died in 1949 than in 1940, in proportion to the population, if preliminary estimates by the National Office of Vital Statistics, Public Health Service, hold up.

The death rate for children 1 to 14 years old, for example, decreased 40 percent (from 1.5 deaths per 1,000 population to .9). This was the greatest decrease in any age group, and it is more than four times as great as the decrease for all age groups combined—9 percent.

For babies under 1 year of age the death rate decreased 38 percent—from nearly 55 deaths per 1,000 population to 34. (This rate, by population, is not the same as the infant mortality rate, which is the number of deaths of babies under 1 year, per 1,000 live births.)

More Medical Supplies Sent to Europe by UNICEF

A substantial increase in the amount of medical supplies shipped to Europe since last spring for the benefit of children is reported by the United Nations International Children's Emergency Fund (UNICEF).

A report prepared by UNICEF presents the increase in terms of millions of dollars. Between April 1 and September 30, the report shows, the total value of medical supplies shipped to Europe rose from $2.6 million to $4.6 million. These shipments included, for example, streptomycin currently provided for 3,000 children in nine European countries and penicillin used in a campaign that has "effectively wiped out syphilis as a major public-health problem in Poland."

The UNICEF supplies have been used in programs conducted under the technical supervision of the World Health Organization (WHO).

WHO specialists will visit most of the European countries in which UNICEF-assisted medical programs are now under way.

The report also points out that UNICEF supplies have helped governments to improve programs for the control of tuberculosis; to expand maternal and child-health services ranging from immunization programs to the newest surgical techniques; and to attack insect-carried diseases such as malaria.

In addition, governments are now submitting programs for the use of UNICEF funds recently allocated for aid to handicapped children in Europe.

Countries participating include: Austria, Bulgaria, Czechoslovakia, Finland, France, Greece, Italy, Poland, and Yugoslavia.

Reprints Available

A limited number of copies of the following reprints from *The Child* are available for distribution. Single copies may be had without charge until the supply is exhausted.

Adolescents Have Special Health Problems. By J. Roswell Gallagher, M. D.

America Welcomes Displaced Orphan Children. By I. Evelyn Smith.

Arkansas Works to Improve Its School Children's Health. By Jeff Farris.

Attitudes Toward Minority Groups. By Annie Lee Davis.

Baltimore's Temporary Group Home Helps Troubled Children. By Dorothy C. Melby.

Connecticut Sends Handicapped Children to Camp. By Ellen E. Ogren.

About the Mailing List for "The Child"

Each year, according to law, the Federal Security Agency sends each person on the official mailing list for *The Child* a postal card asking whether he wishes to continue to receive it.

When you receive such a card, be sure to answer it, if you want your name to be kept on the list.

THE CHILD

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MARCH 1951

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• CALENDAR

Apr. 2-8—National Boys' Club Week. Information from Boys' Clubs of America, 381 Fourth Avenue, New York 16, N. Y.

Apr. 4-6—United States-Mexico Border Health Conference. Los Angeles, Calif.

Apr. 6 — National Health Council. Thirty-first annual meeting. New York, N. Y.

Apr. 5-7—Girls Clubs of America. Sixth annual conference. New York, N. Y.

Apr. 7—World Health Day.

Apr. 14—Pan American Day.

Apr. 14 — Play Schools Association, Annual conference. New York, N. Y.

Apr. 16-20 — American Association for Health, Physical Education, and Recreation (a department of the National Education Association). Annual convention. Detroit, Mich.

Apr. 18-21—International Council for Exceptional Children. Twenty-ninth annual meeting. New York, N. Y.

Apr. 22-28—National YWCA Week. Information from Young Women's Christian Association of the United States of America, 600 Lexington Avenue, New York 22, N. Y.

Apr. 23-25 — Groves Conference on Marriage and the Family. Fourteenth annual meeting at the University of North Carolina at Chapel Hill.

Apr. 26-27 — Groves Conference on Marriage and the Family. Tenth annual meeting at North Carolina College at Durham.

Apr. 28 — American Psychosomatic Society. Eighth annual meeting. Atlantic City, N. J.

Apr. 28-May 5—Boys and Girls Week. Information from Rotary International, 35 East Wacker Drive, Chicago 1, Ill.

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HE CHILD

APRIL 1951

PARENTS CAN BE HELPED TO DO A BETTER JOB

Mothers learn from each other, with the help of a group worker

HELEN NORTHEN

MAY 7 [illegible]

A FATHER AND MOTHER are more likely to guide their children well if they continue to develop their own personalities than if they jog along in a rut. As we all know, mothers especially may become so tied down to diapers and dishes that they begin to feel they have lost their identity as persons.

This is the story of a small group of young women who felt that they were getting into a rut and who did something about it, with the help of a social group worker. They found their opportunities for developing their personalities through a club that they called the "Y-Actives."

Fourteen members made up the Y-Actives. They were all married women, whose parents were Polish or Irish, and all but three had children. Their ages ranged from 24 to 27. All were high-school graduates, but none had gone beyond. Two were working as stenographers; the rest were housewives.

A few, who formed the nucleus of the group, had been teen-age members of the YWCA during their high-school days, when they lived near one another in an industrial neighborhood. Later, when they married, they became a little better off financially, lived in residential neighborhoods, and felt freer of their parents' old-world culture patterns. But in their new homes they missed their former school friends and the closely knit church communities in the old neighborhoods.

A chance meeting between one of these young women and a former staff member of the YWCA led to a reunion of the old group. And they decided to form a club, taking in some other young married women. They hoped "to get time off for fun" . . . "to do more things" . . . "to have some life of our own."

The YWCA agreed to assign a social worker to help with the club, and the Y-Actives came into being.

When the weekly meetings got under way the members chiefly concerned themselves with basketball, volleyball, playing cards, dancing, and eating. Then, after a while, they began making rag dolls for children who had no toys. For, as one member said, "When you're doing some good, you feel good."

Husbands enter the picture

They all talked about how wonderful it was to get away from home once a week, and they began to think that maybe their husbands needed some social life, too. And so they planned to invite the husbands once a month. This, of course, required arrangements for baby-sitting and for caring for older children. But they managed, and the husband-wife parties became regular features of the club program.

After a few of these parties, delighted remarks could be heard during the regular meetings about how much less shy "Hubby" was in meeting new people or how much more relaxed he seemed in dancing and taking part in the other club activities. At one of the parties a couple showed some pictures of their children. Like a flash everyone, amid laughter, got out pictures of junior and sister, and the exhibits were passed around the group. Before the evening was over the club members had planned a family Christmas party for all ages.

The husband-wife parties continued throughout the year, winding up with a spirited dinner dance at a suburban hotel. Planning for this important event included saving money for it over many weeks, giving up other things for it, and putting a lot of time and effort into preparing for it. The willingness of members to plan and save and work revealed their pride in their club and their delight in carrying out social affairs that their husbands enjoyed with them.

Next the Y-Actives took up handicrafts, and they enjoyed the sense of accomplishment that goes with making things (pottery, for instance). Most of them made gifts for their husbands and children, or articles for their homes, such as rag rugs.

As time went on, the weekly meeting became more and more a time for talking over common problems, and these were many. In the relaxed atmosphere of a small friendly group, they discussed such matters as low-cost vacation trips, new labor-saving gadgets, baby sitters, and, more seriously, problems concerning the care and raising of children, prenatal care and care after confinement, difficulties with

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She is now completing her work for the Ph.D. degree in the Graduate Department of Social Economy at Bryn Mawr College, where she is also research assistant. In September Miss Northen will become Associate Professor of Social Work at the University of Hawaii's School of Social Work.

Miss Northen gave this paper at the seventy-seventh annual meeting of the National Conference of Social Work, at Atlantic City, N. J.

their in-laws over such issues as Catholic-Protestant marriages, and doubled-up living arrangements.

The group worker also helped the young women plan more formal discussion meetings, with speakers or educational motion pictures on subjects related to family life.

For example, after the members had been discussing among themselves the difficulties they met day by day in bringing up their children, a staff member from the city's child-guidance clinic was invited to a meeting to talk about child development and about the work of the clinic—how it could help mothers and fathers to understand and to guide their children.

Discussions begin to pay dividends

At other meetings a nurse demonstrated first aid and home nursing. Later the group worker brought in books on sex education and showed movies on human growth and reproduction to help the members in their discussions. Informal talk at following meetings showed that members had been able to make good use of what they learned. One young mother, arranging to borrow a book on sex education, said that she needed it because her 4-year-old daughter was at the question-asking stage. She had asked, for example, why her aunt—obviously pregnant—was "getting so fat."

The mother was proud of herself for having been able to answer the little girl's question in a natural way, and she felt that she had been able to do that because she had learned so much in an earlier group discussion. Other mothers showed from time to time that they were beginning to understand themselves and their children's behavior better, and as a result were finding more satisfaction in being homemakers.

Gradually, the young women began to see that some of their own family concerns had a wider meaning; their concerns could be applied to the community as a larger family group, closely interrelated. They began to discuss such matters as how can better housing be achieved for all families, what are the respective roles of the family and the school in sex education, and how much the community needs more child-guidance and other children's services. While they talked about this need for more services they learned about the central money-raising activities of the community chest. And they began to realize what it means to families and children that need specialized services, whenever the people of the city fail to give the full amount budgeted for these services. A direct result, for example, was that a child-guidance clinic might have too small a staff, and be obliged to turn away parents and children who needed service, or postpone giving them service because of a long waiting list.

Family life is sometimes improved for both children and parents if the father and mother have opportunities to develop their own personalities instead of jogging along in a rut.

Some difficulties call for individual help

Most of the young women gained the help they needed through the weekly contacts with one another and through discussion of the problems they were themselves wrestling with. From that point they could learn by applying their new knowledge or by following up their questions with reading or going to other sources of information that they had learned about at the club meetings.

A few members, however, had difficulties that they could not overcome solely through this group association. There was, for example, young Mrs. O. The group worker early guessed that this young woman needed individual help before she could benefit from the group experience. The worker could not help noticing how changeable Mrs. O became — she would be taking a cooperative part in the group's activities, and suddenly she would change to silence or aggressiveness. The worker watched and listened for reasons for this erratic behavior. After a while she heard Mrs. O remark that if she had a chance to decide again about getting married, she certainly would stay single. And she mentioned evidences of home difficulty, such as disagreements with her husband about disciplining the children; she brought a cousin instead of her husband to one of the parties; she talked about the trouble she was having with her in-laws because they objected to the marriage on religious grounds.

Mrs. O did gain some support from the other members' sympathy for her and their suggestions about dealing with her problems. Meanwhile the worker, who had developed a close relation with the troubled young woman, made her aware that she knew things were hard for her and offered her an opportunity to talk about finding help.

But Mrs. O's condition became increasingly worse. Finally she got so that she could not bear to have differences of opinion in the meetings go against her. One night, when things did not go her way, she resigned from the club. The worker made an opportunity that very night to talk with Mrs. O about why she was leaving, and Mrs. O asked her for an appointment for a personal talk. In this later interview the group worker enabled Mrs. O to realize her need for help with her marital difficulties and her children's behavior problems. The worker helped her in making an appointment with the local family-service society to seek the assistance she needed.

In the relaxed atmosphere of a small, friendly group, it is easy for young mothers to discuss everything from labor-saving gadgets to the serious problems of family life.

Another member, Mrs. H, after she listened to other members tell of their experiences in raising their children and after she heard the talk by a staff member of the child-guidance center, showed her need for help in understanding the difficulties of her own little girl. Mrs. H evidently could not, by herself, overcome her feelings of inadequacy about the way she was raising her daughter, and she welcomed the idea that she take her to the child-guidance center. Unfortunately the center had so long a waiting list that Mrs. H could not get help until some time later. Meanwhile, though, her difficulties were lessened somewhat by the aid and support she got from the other club members and from the group worker, and she felt more confident in handling her problems.

These steps toward more successful family life, which were obviously fulfilling the desires and needs of the club members, did not just happen. These young adults had been starving for social life; they felt strongly that they needed a means of greater self-expression. And they poured thought, time, and energy into their efforts to advance. But they were not without guidance. At every step of the way, the social group worker was there to help them.

The worker had some knowledge and understanding of human behavior, particularly of child development, and had studied the problems of adjustment of young married couples. She knew each member as an individual—what her special interests and needs were and how her family situation and community conditions were affecting her. She knew about a variety of program activities and how they could be used in helping individuals to develop their personalities and the group as a whole to achieve its objectives.

Step by step

Thus, she had begun by helping the members find release from the tension of home responsibilities through a weekly evening of active recreation. She knew that this need must be met before the group could focus on anything else. She understood, however, that the more fundamental need of most of the members was to succeed as wives and mothers. At appropriate times the worker encouraged the members to ask her cooperation in developing social activities that they could share with their husbands. She helped the members to come to the point of voicing their desire for help in resolving their problems of married life and of child rearing. She tried to lead the discussions in such a way that each member could take part, and to cultivate each one's sense of confidence in her ability to help the others.

The formal programs—the talks by specialists, the showing of movies—and the introduction of reading matter were successful, partly because the worker prepared the group in advance, and because the meetings were followed by discussions that answered questions and cleared up misunderstandings. Finally, when the club was ready, the worker helped the members to realize that some of their personal problems were related to wider community problems. Thus, the worker helped the group to deepen its own program, moving from recreation to the study of problems whose solution might lead to the strengthening of family life.

How the members of a group get along with one another is a factor in how they are able to profit from

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TO RESTORE THE CHILD WITH CLEFT PALATE

Professional and community teamwork will bring success

SAMUEL M. WISHIK, M.D.

WHEN A CHILD is born with cleft palate the family feels that it is a disaster, and often it becomes one. The parents feel that they must be to blame, and they are ashamed because they have produced an imperfect offspring. They feel stigmatized in the eyes of their neighbors and of society. The father and mother, as well as the other children in the family, may suffer emotional disturbances.

If these parents had known beforehand something about such defects as cleft palate and harelip (these are likely to occur in the same child) and had realized how much can be done to restore the child they would have been saved much unhappiness. People in general need to know more about the speech and facial defects that occur as a result of cleft palate and harelip. And they should also learn to see these defects in proper perspective with the person's other attributes. Too often do we jump to conclusions about a person's mental capacity because his speech is defective or his face is marred. More widespread information on such congenital defects and greater understanding of them would lead to better social acceptance of the individual.

Complete correction possible

The most hopeful aspect of cleft-palate correction is that with well-timed and adequate care 100-percent rehabilitation is possible in a large proportion of children. So far as we now know, cleft palate differs from certain other congenital and childhood handicaps in this possibility for complete or almost complete correction. We can attain for a child remarkable cosmetic results with surgery for harelip; effective closing of the cleft palate by surgery and use of mechanical devices; and ability to speak normally or almost normally through closing the child's palate and training him in speech. And consequently, wholesome social, psychological, and vocational adjustment to life becomes possible for him.

It is not necessary to be content with a partial result or a residual handicap. A large percentage of persons born with cleft palate should be able in adulthood to forget completely that they had had the condition when they were children.

Heredity is probably not a factor

Although we do not know the whole story of the factors that produce cleft palate and harelip (and similar defects such as clubfoot and birthmarks) in a child before birth, we do know that they result from *incomplete* development rather than from *abnormal* development. We can theorize that the child born with harelip or cleft palate would have developed normally, with the lip and palate closed properly, if something had not arrested his growth before it was completed. We should not conclude that heredity is a factor merely because statistics indicate that these conditions often occur in several members of the same family, for it is possible that this could be due to environmental factors, such as faulty diet or disease. Studies made so far seem to give strong evidence that the physical condition of the mother during pregnancy may affect the completeness of closure of the child's palate or lip before birth.

In view of what we now believe about the causes of such defects as cleft palate, public-health programs for maternity care should give particular emphasis to better nutrition during pregnancy and to prevention of illness during the early months — especially prevention of certain communicable diseases. In addition, recent research suggests that good health in the mother during the period before conception is a possible factor in preventing congenital anomalies.

Cleft palate, harelip, clubfoot, birthmarks, and some other congenital anomalies have many factors in common. They resemble one another not only in being present at birth but also in provoking similar attitudes in the community, the family, and the patient. Besides, the same kinds of social, psychologic, educational, and vocational problems accompany them.

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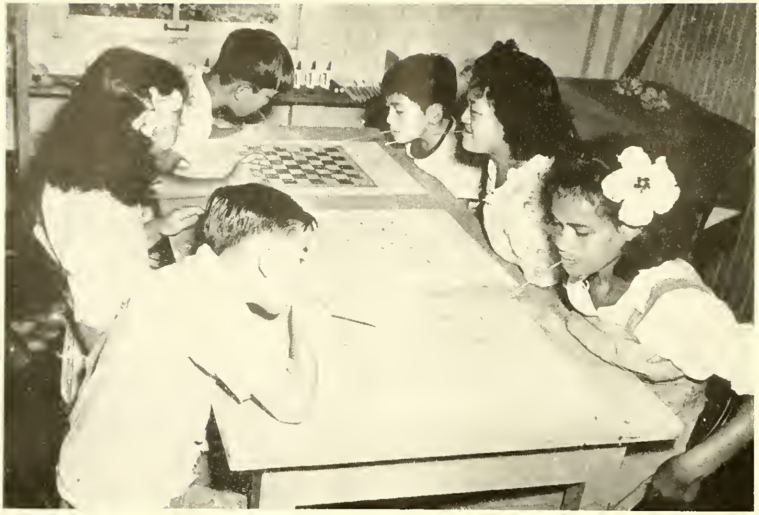
Dr. Wishik gave this paper at the seventh annual meeting of the American Association for Cleft Palate Rehabilitation, held at Columbus, Ohio.



This is fun, but it is also part of the treatment for these school children with cleft palate.

These problems have profound and varied effects on the relation between the individual and the rest of the community, and thereby place responsibility upon the public to aid in their solution.

Although this paper is concerned specifically with congenital anomalies, it applies also, in varying degrees, to certain other conditions, usually acquired during early childhood, such as strabismus or squint. These resemble congenital anomalies in their effects upon the child's educational opportunities and vocational accomplishment. All these conditions have similar psychologic and social effects on children, and require similar community efforts to meet their needs, and especially to help them to be accepted by other people.

Child needs to experience success

If such a child is accepted by people he is likely to become better adjusted. Nevertheless he will have many troubles if he is not given the help he needs toward getting special schooling, speech instruction, and assistance in vocational planning. It is well known that maladjustment comes not only from one's own feelings and the attitude of others, but from lack of success in meeting the daily problems of life.

In school the child with cleft palate faces greater obstacles than other children do. He may have to stay away from school again and again for surgical treatment. Some children develop ear infections and as a result have difficulty in hearing.

By far the greatest difficulty these children face in school is not being able to talk clearly. And the chances are that the child will not find in his school any opportunity for the special lessons he needs. Speech instruction is one of the weakest elements of our educational system. In every school some children have speech defects that require special instruction to help them get an ordinary education, but very few are receiving such instruction. State and local school boards need to exert greater effort so that most of these handicapped children can get an ordinary education, and so that children who need special education can get it.

If a child's cleft palate is not corrected by the time he reaches the age for entering employment, especially if he still has trouble in speaking, he will have less opportunity for jobs than the average youth. With the recent remarkable technical advance in devices for mechanically closing the palate, we hope that job difficulties due to defective speech accompanying cleft palate will decrease.

Until we can eliminate such speech defects entirely, such young people will have limited opportunities for employment, and they will continue to need special vocational help. For each youth so handicapped his parents and everyone else concerned should recognize as early as possible the probability that he will be limited in his opportunities for jobs and should consider this probability in planning his schooling. During his early high-school years, at the latest, vocational plans should be made and appropriate training begun.

The best occupational planning and training, however, will fall short of meeting the problem so long as many employers continue to resist employing handicapped persons. The public employment services can render greatly needed help to this group of handicapped young people, not only by finding suitable job openings, but also by providing counseling service in the light of local vocational opportunities.

Public and private resources are needed

The rehabilitation of persons with cleft palate requires a teamwork approach by different professions and by various types of community agencies. Even the medical aspects of the care of cleft palate cut across a number of medical specialties, and include, among others, treatment of cosmetic factors, of dental defects, of feeding difficulties, of speech disturbances, and of hearing impairment. The battery of medical and allied personnel that is called upon includes the pediatrician, the plastic surgeon, the rhinologist, the otologist, the dentist, the orthodontist, the prosthedontist, the psychologist, the social worker, the hospital nurse and the public-health nurse, the nutritionist, and the public-health administrator. Special education calls upon the speech correctionist, the special teacher for the hard of hearing, the vocational counselor, and the teacher giving vocational training. Community resources called into play include private doctors and dentists, hospital clinics, the public-health department, the school system, and agencies for vocational rehabilitation and placement.

A cleft-palate team might conceivably be set up in a clinic by a voluntary agency. To employ the full complement of professional personnel required is so expensive, however, that some type of direct or indirect support from public funds is almost invariably necessary. If the many community resources contributing to the cleft-palate team are to cooperate effectively, the interested public agencies must participate fully. In addition, to keep the team operating smoothly, one of these public agencies should coordinate the official and voluntary resources into an integrated community program.

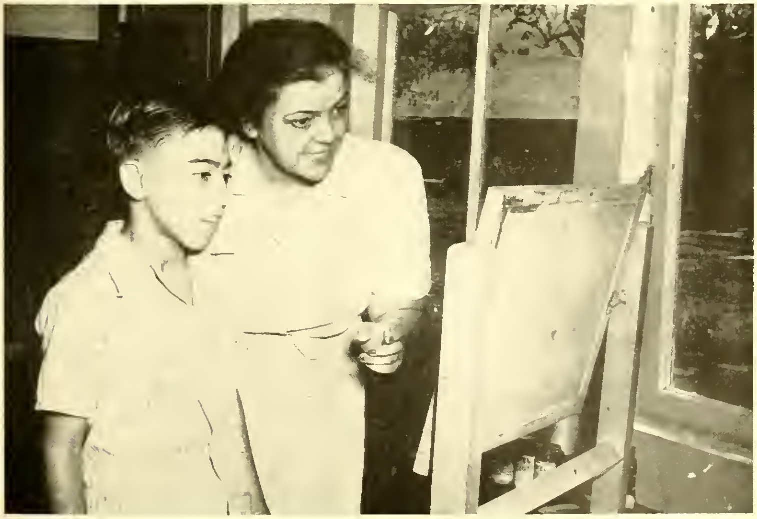
Team training for workers

It is not sufficient to establish and support a setting for professional and community teamwork for correcting congenital anomalies such as cleft palate. It is also important that professional workers *train* together so that it will be easier for them to become part of the team. By such team training each professional worker would learn the role he plays, together with members of other professions, in a well-rounded rehabilitation program for children with these anomalies.

Establishing and maintaining training centers for workers to deal with specific conditions such as cleft palate, cerebral palsy, or rheumatic fever is expensive and can be borne by few university centers. It therefore becomes a public responsibility to recognize and to meet the great lack of personnel trained and qualified to give care for such special conditions and handicaps. Public funds are needed to support the development and maintenance of a number of training centers in different parts of the country. Additional funds should be forthcoming for scholarships and fellowships to enable people with adequate basic professional background to prepare themselves by postgraduate study to contribute to rehabilitation programs.

To obtain reliable statistics on the incidence of cleft palate, some type of *central registration* should be established in each large city, and in each State, for areas not otherwise covered. From such data studies can be made from which possible correlations with causative factors might be derived. In addition, more accurate information on the number of persons affected in different areas and in different age groups would be valuable in establishing community policy and in stimulating interest in expanding available services. Central registers should be limited to major identifying information, to compilations of numbers of persons, and to data needed for special studies.

A speech therapist is using a mirror to help this youngster to learn to speak normally.



For continuity of service to the child

The effectiveness of the central registration register depends upon the completeness of reporting by private practitioners and by agencies giving care to children with cleft palate. A report should be made soon after the child is born. Many communities have an item on the birth certificate concerning congenital defects. And physicians and hospitals responsible for filling in birth certificates should furnish this information conscientiously. In addition, in some communities special reports on certain types of defects are made to the health department.

The child with cleft palate needs rehabilitation services for a long time—at least throughout the growing years of his life. Almost at the beginning we can establish a rather accurate timetable on the care the child will need as he grows. This timetable may include lip closure in the first weeks of life; consideration of the advisability of surgical closure of the palate during the preschool years; pediatric and medical social service, and special dental care throughout childhood; speech instruction before entering school if possible, and certainly in the lower school grades; use of prosthetic appliances during the school years; orthodontic work in adolescence; and counseling, social services, and vocational planning and training during the adolescent years.

Too often, despite the possibility of setting a timetable for meeting needs, the child is lost sight of and care is discontinued. It should not be that professional services are rendered only in response to the family's seeking such services, for there is no common-sense method

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FOR THE CHILD WITH NO FAMILY OF HIS OWN

ALMEDA R. JOLOWICZ

"THIS BABY has nobody of his own that he can count on. He has only the county welfare department, and we must find some kind of home for him that can become his own." That is what we of the department staff say to ourselves when a child under our care seems at first to be "unadoptable." In spite of the adverse opinion of others about a baby, we strive to place him in a permanent home through adoption, for we believe that every child belongs in a family of his own.

One of these "unadoptable" babies is Charles, the child of an unmarried mother, who was born by a breech delivery, with clubfeet. After his feet were placed in casts, he developed feeding difficulties. And during the next 2 weeks his spasms, crying, and spastic movements led the hospital doctors to believe that he had cerebral palsy. Later they changed this diagnosis, on the ground that before birth he may have had a cerebral hemorrhage that had since been absorbed. They thought that regardless of this possibility the baby might not be entirely normal.

At this point a social agency referred Charles to our department of welfare as "unadoptable." We placed him in a boarding home; there he has developed into a good-natured, contented baby, thought by his foster parents to be quite smart. The doctor has had him fitted with braces and orthopedic shoes, and he is expected to need orthopedic care for about 2 years.

If a mother decides to give up her baby, he may have no one of his own to count on.

His foster mother thinks she noticed a spasm lately, but we think she may be mistaken, for we know that the baby's grandmother told her about the physical difficulties he had had during his first weeks of life. We plan to have Charles tested by a psychologist and reexamined by a neurologist. Knowing already that the baby's mother is an emotionally immature, self-centered girl who sees no connection between her own life and her child's destiny, we know that Charles can count only on us. We want very much to find some family who will adopt him for their own.

Our agency, the Nassau County (N. Y.) Department of Public Welfare believes that an agency charged by law with the care of destitute, neglected, and delinquent children, children physically and mentally handicapped, and children born out of wedlock must administer a complete program of services for these children, if it is to serve them responsibly.

Acting upon this conviction, our department administers an adoption program as one of its services to the children of unmarried mothers and to other children whenever placement in an adoptive home is thought to represent the soundest planning for them.

The number of children for whom we find adoption to be the soundest plan is relatively small, in compari-

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Mrs. Jolowicz gave this paper at the seventy-seventh annual meeting of the National Conference of Social Work, at Atlantic City, N. J.

son with the total number in our care. But the number for whom we consider placement for adoption and later find unadoptable is still smaller. This latter is indeed fortunate because the problems encountered in providing foster care for unadoptable children are serious.

Skill needed in helping boarding parents

When an agency decides, on the basis of careful planning, that long-time care in a boarding home is the best plan for an unadoptable child, the selection of a home must be made with great care. The boarding parents should be as carefully selected for their suitability to the child as if they were to be the adoptive mother and father. They should really want to keep a child for a long time without the finality of adoption. In spite of this care in selection, however, problems will grow out of this situation. And as the child's stay in a boarding home stretches out through the years, the agency will have to anticipate these problems and try to avoid them. If difficulties cannot be avoided through anticipation, they may be at least kept from becoming so serious that they jeopardize the child's stability. The workers will have to use all their skills in helping boarding parents to realize that the staff will continue to share with them the responsibility for the child's well-being in more ways than by issuing a check each month.

The staff should appreciate the fact that long-time boarding care, even in one family home, does not offer full security to a child. This is because he knows that he does not really belong in the foster family. The child will need help in understanding why his name differs from the name of his foster parents and in explaining this difference to other children and to his teachers. The staff should be aware that the child will have questions about why his own people gave him up and why his foster mother and father did not adopt him. The staff must realize that the child may never ask these questions; but the uncertainty they cause, unasked, may affect adversely his concept of parents and also his attitude toward himself. How staff members of the agency may help a child to ask his questions, and how they may answer them satisfactorily, is something we must give more thought to.

The children we have had to keep in boarding homes because we found them to be unadoptable fall into three groups, which are—

1. Children who were not legally free to be adopted, although their satisfactory development made them eligible for adoption;
2. Children who had major physical defects or who had in their background a combination of questionable factors;
3. Children whose personalities were warped by being left too long in boarding homes without having any close family ties.

I have not mentioned children that might have been considered poor adoption risks because of hereditary factors. But in recent years we have not had a child for possible adoption in whose background we knew there was some disease or condition that has been clearly established as hereditary, such as Huntington's chorea or hemophilia. We have, however, approved for adoption children who had in their background some disorder such as mental illness or epilepsy, the transmission of which by heredity is less clearly established. That the adoptive parents are given full information about such disorders in the child's background goes without saying.

Incidentally, there is one group for whom we have found it difficult to plan either adoption or boarding-home care. These are the Negro children. An extensive drive for boarding homes for all types of children was made last year for several months. A special appeal was made for Negro boarding and adoptive homes. But neither newspaper stories, radio broadcasts, contacts with the members of Negro churches and of other groups having Negro members, nor the formation of a lay committee made up of white and Negro members have produced any adoptive homes and only one or two boarding homes. Our nearness to New York City and other conditions in Nassau County, and the failure of the department so far to find the right channels into the Negro community are possible explanations of our lack of suitable homes to consider as permanent ones for Negro children, through adoption.

Let us look at the children who are not legally free for adoption. For example, a child is not legally free for adoption if he is born to a married woman whose husband is not the father, unless the husband signs a release for the child's adoption. The cooperation of the husband is required in the adoption proceedings because a child born to a married woman is by law considered to have been born in wedlock. Since the husband does sometimes cooperate, not all children born under these circumstances are unadoptable. He will sometimes sign a surrender of his right to the child or will submit evidence to the court that the child was "begotten and born" during his separation from his wife. Sometimes a mother, however, simply cannot face disclosing to her husband that she has had a child by another man. And she can make no plans to include the child in her life if she hopes to preserve her marriage. For such a child, long-time placement in foster care may be the only possible plan.

Physical defects make adoption difficult

Among the second group, the children who have some major physical defect or some combination of factors in their backgrounds that make their potential development questionable, there are varying degrees of unadoptability. Two children illustrate the kinds of medical problems that would prevent our even considering some children for adoption.

One of these children is a little boy born in a State hospital to a mother whose illness was diagnosed as a psychosis with epilepsy. In infancy the boy was found to be mentally and physically retarded and to have a condition diagnosed as the petit mal type of epilepsy. The other is a 3-year old girl with a congenital heart condition that has kept her in a hospital for all but 10 months of her life.

Another child, a girl, who was born with one arm but who has developed normally except for this defect, we shall place in an adoptive home if we are able to find one for her. We accept a principle that the Child Welfare League of America has stated about children legally free for adoption, that any child can be placed for adoption if a family can be found who will accept him, with his history and his capacities.

It is readily apparent, however, from the instance of this one-armed girl, that the practical application of this theory presents problems not easily solved.

The resources and skills of a welfare department are also taxed to the fullest in providing a good environment for children so handicapped, who cannot be placed for adoption because their serious physical condition creates recurrent crises in foster homes. Caring for such boys and girls requires so much of a foster mother's energy and time and is such a responsibility that even by paying extra board rates it is difficult for us to find a family that can bear the strain year in and year out. Often when one of these children has to go to a hospital, the foster mother makes his going an occasion for giving him up entirely. When the child is ready to leave the hospital and the foster mother is unwilling to take him back, there may not be enough time for the agency to find "just the right home." Consequently, we must place the child in a home that may not be perfectly suited to this particular child. Then we may have to move him soon. And so, in addition to his initial handicap of physical defect and lack of family ties, the child undergoes the misfortune of being placed in one foster home after another.

We in our agency consider one more group of children unadoptable, perhaps the largest group of all. These children have become unadoptable through the mistakes of social agencies, either private or public. Some are children who were not placed early enough because their backgrounds were considered too poor, but who turned out to have potentialities for normal, healthy development. Some are children who were not placed for adoption because their mothers were not helped to make permanent plans for them; others, simply because they were overlooked. Their case records are depressing reading; these reveal the impermanence and instability of a child's life in boarding homes. We in social agencies that carry long-time responsibility for children must face squarely the fact that boarding homes offer very little permanence. Any happening that disturbs family life affects a child who has no legal ties in the home much more poignantly than they affect real members of the family. These disturbances may grow out of such national catastrophes as mass unemployment or war, accompanied by a great moving about of families, or from such family problems as having adult sons and daughters return home because of divorce or widowhood, or from having other relatives move in because of the housing shortage; or from illness or death in the foster family. All leave deep marks on the "boarding" child.

Handicapped child may lose foster home

Even children who have had the advantage of staying in one boarding home grow up with a considerable feeling of insecurity, because they knew all the time they really didn't belong in the families they lived with. Exceedingly destructive to a child's sense of security in such a situation is the fact that he cannot identify himself with the family as he would with his own parents and brothers and sisters. His natural resentment at not having a family of his own and his sense of not belonging to his boarding parents sometimes prevent him from climbing into the lap of the foster family and feeling secure.

This is one reason, we believe, why some of these children, as they reach the age when foster care for them must end, have no ambitions, no aims, no sense of direction in their lives. Sometimes one of them manages to pick up a little information about one or both parents (often, unfortunately, unhelpful information) and may identify himself with the father or mother. For example, a girl born out of wedlock learned something about her history; later when she became illegitimately pregnant, she said to us: "I'm just like my mother."

The plight of these children, who became unadoptable through the lamentably poor work of social agencies, whose loneliness, whose unhappiness, whose delinquencies, whose inadequacies really represent the failures of social agencies rather than their own, will eventually force these agencies to develop adoption programs adequate in principle and practice to meet the needs of children who, without ties of their own, should be given a chance to make permanent ties with new fathers and mothers. Realizing how much we can help build good lives for these children, the Nassau County Department of Public Welfare today considers for adoption boys and girls who 10 years ago, or 5, or even 2 years ago would have been doomed to spend their childhood in boarding homes.

The factor of unadoptability may greatly complicate work with unmarried mothers and their babies. If the mother has decided that it is clearly best for her and the child that she give him up for adoptive placement, the right plan is to place him for adoption as early as is safe for him. But a complicated problem may arise in connection with the mother's surrender of her right to the child as a step toward placing him for adoption. It grows out of the threefold responsibility of the public agency toward the community as a whole, to the parent, and to the child. The community delegates its responsibility for the care of the unmarried mother and her child to a public agency that it has created and that it supports and holds accountable. The legal counsel for our department has advised us that in New York State it is the intent of the law that no child shall be deprived of parental support. Thus, no parent, by signing a surrender of his rights before knowing whether his child is adoptable, is released, according to law, from his duty to contribute to the support of the child if later the child is found to be unadoptable.

Application of the viewpoint expressed in the New York law may solve the problem of support of the child but may create others, particularly for an unmarried mother. A release from all reminders of her illegitimate pregnancy and of her child — unadoptable because of some defect — would often serve the interests of an unmarried mother best. Such a release, however, might not serve best the interests of her child, theoretically at least, because it would deprive him of his own family background and heritage for which not even adoption can provide a substitute. Such a release would also make the community responsible for the support of the child. The community, however, is not at present willing to assume this responsibility in full, and therefore requires the mother to pay what she can. On the other hand, the act of not releasing the parent from responsibility may not insure parental support or family ties that are beneficial to the child, and may seem to punish the mother.

In Nassau County we fully accept the law's point of view that a "surrender" is only an instrument for use in adoption proceedings; and having accepted it, we find that the best interests of the community, of the mother, and of the unadoptable child do not necessarily conflict with one another. The mother who wishes us to place her child for adoption knows from the beginning that we will not accept from her a surrender of her right to the child until our observation of him, substantiated by reports from a pediatrician and a psychologist, shows that he is adoptable.

The mother learns also that if her child is found to be unadoptable we will help her plan otherwise for him and we will explain the responsibility she will be expected to carry. We know that the saying, "You can't get blood from a stone," has a grim sort of reality for social workers, and that nothing can be gained by attempting to force a mother to keep up her natural relation with a child she does not want, especially when she shows her lack of love in a way harmful to him. We appreciate this difficulty fully, and are aware that even though the mother has not surrendered her right to such a child, there may be nothing for him except what our department can offer. Therefore, we deliberate much more carefully before we decide that he is unadoptable. That is why we shall try so hard to find parents for Charles, whose situation we described earlier, in a home to be his own.

The more we broaden our concept of children who are adoptable and the more we find permanent homes for children difficult to place, the more we help both mother and child.

Every child needs a family—his own or an adoptive one—to give him security and love.

Mother will need help

If, after we have expended all consideration and effort, we find that a child cannot be placed in an adoptive home, we believe we must help the mother to bear this harsh reality. Certainly, no one worthy of being called a caseworker would use the fact that a child is unadoptable in order to punish a mother. Though our interpretation of the law does not permit the department to release a mother from her responsibility to support her child, yet, as the years pass, if the turn of events in her life makes it impossible for her to continue to play a part, financially or otherwise, in the life of her child, the department will assume responsibility for him. We will place him in group or family foster care, whichever is best for him, and will do our part in caring for him as long as our responsibility lasts.

This seeking to widen the sphere of adoptability for the children whose course we are expected to chart, we consider at present one of the dominant activities of our program for unmarried mothers and their babies. Our concentrated efforts began as recently as 1948, although the department has always placed some children for adoption. During the past 3 years we have been able to bring more focus and more direction to our adoption work by centralizing in one supervisory unit our work with unmarried mothers and with all children for

(Continued on page 152)

IN THE NEWS

National defense.—Quick surveys are being made of health and welfare conditions in areas that will be affected by the Atomic Energy Commission's new projects in various parts of the country. Regional offices of the Federal Security Agency, through representatives of the Children's Bureau and of other constituent agencies, are making these surveys with the cooperation of State departments of health and welfare, at the request of the Commission. Staff members are preparing analyses of the conditions found, in the light of the emergency changes expected; these analyses are for administrative use only.

Typical of the new projects is the Savannah River Project. This is located on the South Carolina side of the river, about 30 miles below Augusta, Ga. The surrounding area, where the workers and their families will live, is expected to include 12 counties—7 in South Carolina and 5 in Georgia.

The plant itself is to be designed, constructed, and operated by private industry, for the Commission. It will be built on a site covering 200,000 acres, and all the families living on that land will have to move, as no residences are to be located on the project site. Estimates are that 1,500 families will have to find new places to live.

The emergency problems of these families, and of thousands of other families that will be moving into the area around the project site, will undoubtedly require a great increase in maternal and child-health and social-welfare services. For the survey makes it clear that the services available to the people now living in the area will not be adequate to meet the needs of the thousands of families who will be coming in. And as the population grows and congestion increases, many families will need help in adjusting to life in a new place, where housing, school facilities, and recreational opportunities will probably be inadequate, as well as health and social services for mothers and children.

Additional maternal and child-health centers will be needed, in locations where people can get to them easily. And with children coming into the project area from all over the United States, those of school age will especially need services, among them immunizations and dental services. Plans for meeting the health needs of mothers and children should not only provide the usual health services for them, but should take into consideration their social and emotional needs.

Only limited day-care facilities were found in the area. If mothers of young children take jobs, day-care services will have to be provided.

Teen-age problems are likely to be increased in new communities, and ways to meet these will be needed.

During the construction period for such a large project, with a concentration of single men, the illegitimacy rate is likely to rise in the surrounding communities, where conditions will be unstable and community services lacking. Some girls and young women will need help in planning, not only for their babies, but for their own future lives; many of them will not be able to pay for care during pregnancy.

Other social problems will be intensified and will become more widespread on account of the unsettled conditions that such a great outgo and influx of people is likely to bring, and social services to meet these problems will be needed.

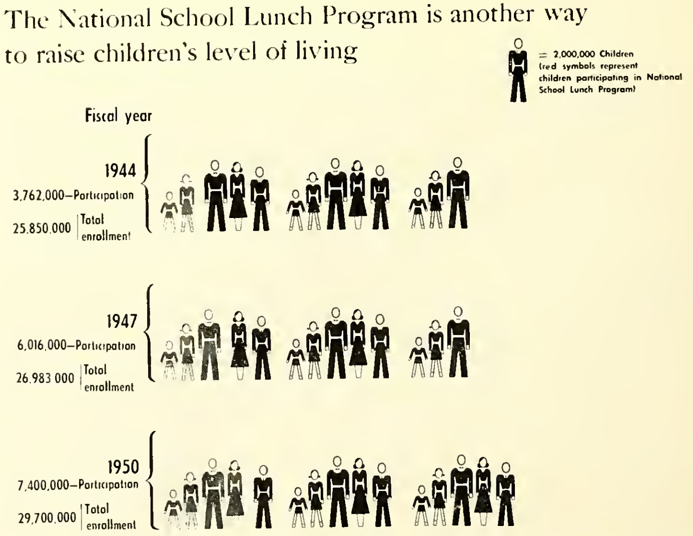
A similar quick survey has been made in the area affected by the Paducah (Ky.) atomic project. This area includes eight counties in southwestern Kentucky and three in southern Illinois.

UNICEF.—A traveling dental office and a mobile X-ray laboratory, designed to take health services to the children of rural Uruguay, have been shipped by United Nations International Children's Emergency Fund (UNICEF) for use in that country's maternal and child-health program.

Number of births.—More babies were born in the United States in the 5 years since the end of World War II (1946-50) than in any previous 5-year period in our history. The 5-year total came to 18½ million.

Registered births in 1950 are estimated by the National Office of Vital Statistics, Public Health Service, to be 3,548,000, compared with the final figure of 3,559,529 for 1949. The record high, in 1947, was 3,699,940 registered births. If unregistered births were counted in, NOVS believes 1950 births would total 3,690,000.

Birth rates based on registered births per 1,000 population were 24.4 (provisional) in 1950, 24.9 in 1949. 25.3 in 1948, and 27.0 in 1947.


The National School Lunch Program is another way to raise children's level of living

4-H Club idea.—Rural youth clubs have spread rapidly in Latin America during the past year, according to the U. S. Department of State. The clubs are patterned after 4-H clubs in the United States. In the countries south of us, the Institute of Inter-American Affairs is helping to get them started and growing. A recent survey shows 413 such clubs, with 8,300 members, in seven Central and South American countries.

Like the 4-H Clubs sponsored by the U. S. Department of Agriculture, the Latin-American clubs have projects that vary according to the social and agricultural needs of the community.

General guidance, especially on technical projects, is given through the "Servicios Cooperativos," the device developed by the Institute to obtain close international cooperation in technical matters among the American Republics.

"ADC."—Families receiving aid to dependent children, under the Social Security Act, continued to increase in number during the first half of 1950, but the number tended to level off in the last half. The number of families aided in December, about 640,000, though 40,000 above the number in December 1949, was nearly 15,000 smaller than the number in June 1950. Thirty-two States shared in the June-December decrease and 14 States had decreases from the previous December.

Opportunity for employment was generally better in 1950 than in 1949. The amendments to the old-age and survivors insurance title of the act that became effective in September 1950 raised the benefits of some families who previously had needed aid to dependent children to supplement the insurance benefits; other ADC families became eligible for benefits under the amendments. The resumption of United Mine Workers' Health and Welfare benefits took some additional families off the ADC rolls. In a few States, reductions in the number of families receiving ADC payments resulted from administrative cuts to keep expenditures within appropriations. These cuts were made because the appropriations had not kept pace with increases in the number of families needing this aid to dependent children and in the cost of living. Some other States reduced payments instead of the number of families receiving aid.

The 1950 amendments to the ADC title of the act relieved the finances of most State public welfare agencies to some extent; through these amendments, Federal funds can now be used to pay part of an amount included for the mother or another adult relative who cares for the children, if that relative is taken into account in determining the amount of the payment. In some instances, also, Federal funds were part of the assistance given to fathers incapacitated for work. This was under the new category of "aid to the permanently and totally disabled." The new Federal funds made it possible for some States to restore or reduce earlier cuts in payments or to increase allowances for food or other requirements to bring them more nearly in line with current prices.

Average payment for all States was $74.17 in December 1949, $70.37 in June 1950, and $70.61 in December 1950. The number of children aided per family averaged slightly more than 2.5.

Infant mortality.—The lowest infant mortality rate ever recorded in the United States occurred in 1950, when the estimated rate was 29.2, Public Health Service's National Office of Vital Statistics reports. This represents a drop of 6 percent from the rate of 31.1 for 1949, and of 38 percent from the 1940 rate, which was 47.0.

Rates are based on the number of deaths under 1 year per 1,000 live births. Actual number of infant deaths in 1950 is estimated as 103,700.

FSA represented.—Many decisions of the Office of Defense Mobilization will affect children in some way, through their families or through public services. The Office's Manpower Policy Committee, brought into being by defense mobilization order No. 5, is directed by this order to add to its membership, when housing and community services are being considered, the Housing and Home Finance Administrator and the Federal Security Administrator, under whom the Children's Bureau functions.

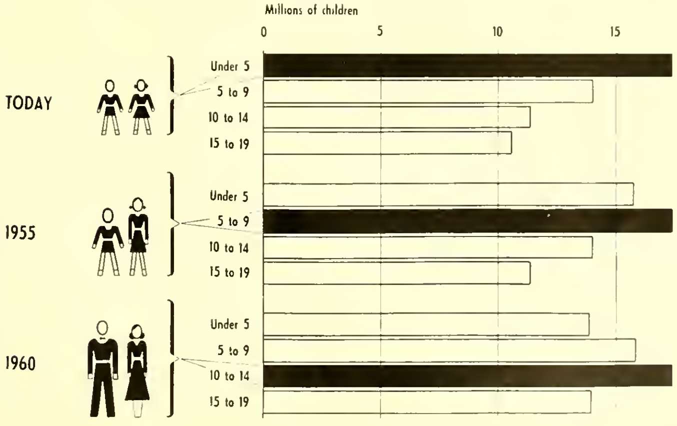
Shortage of nurses.—Ten percent of all girl high-school graduates in this country will have to be recruited as student nurses to obtain the minimum of nursing womanpower proposed by the American Nurses' Association for 1960, according to Ruth Freeman, R. N., nursing consultant with the National Security Resources Board and associate professor of public-health administration at Johns Hopkins University.

The National Security Resources Board's Health Resources Advisory Committee is studying the need for nurses and will soon be able to state definitely the minimum number needed. Meanwhile, the American Nurses' Association has estimated, Miss Freeman says, an immediate need for at least 63,000 more nurses than are now active.

Miss Freeman points out that it would take several years to catch

The post-war "wave" of births requires rapid changes in services and facilities

Adjustments must first be made for toddlers, then school-age children, and finally adolescents



up with the existing deficiency in nurses "even if we get the most we have any right to expect."

School lunches.— More than 8½ million boys and girls—a new record — took part in the National School Lunch Program in November 1950. This tops the previous record number, reached in 1949, by 10.5 percent.

Over a billion and a quarter meals were served to these children in elementary and high schools during the 1949-50 school year, 64 percent of the meals being what is known as the type-A lunch. That is a complete meal, containing one-third of the body's nutritive requirements for a day.

School-lunch officials in the Department of Agriculture, which administers Federal grants for this program, estimate from present trends that 1950-51 figures will show an increase of 164,000,000 meals served, and that 67 percent will be type-A lunches.

Despite the notable strides reported, this program, in operation in all the States and Territories, still reaches less than a third of the nearly 30,000,000 pupils in elementary and high schools.

WHO nurses.—Twenty nurses from Switzerland, South Africa, Denmark, Great Britain, Eire, United States of America, Canada, and Holland are now working in scattered outposts of the United Nations World Health Organization (WHO).

Wearing no special uniforms, they frequently live under primitive conditions with WHO field teams and missions in jungles and stricken villages. Their duties take them to such widely differing countries as Borneo, Greece, China, Egypt, South Korea, Pakistan, Ethiopia, India, Haiti, Thailand, and Malaya.

Mortality statistics.—An invaluable tool in planning programs for lowering mortality of prematurely born and newborn babies, statistics on these deaths are getting special attention these days. Much of the usefulness of these figures to health and medical workers depends on the comparability of the data. Recommendations for better data-gathering have been released by the Public Health Conference on Records and Statistics, the Association of Maternal and Child Health and Crippled Children Directors, the Children's Bureau, and the National Office of Vital Statistics. Copies of their joint statement, which is of interest to public-health workers as well as to statisticians, may be obtained from the Children's Bureau or the National Office of Vital Statistics, Federal Security Agency, Washington 25, D. C.

From the census.—Census figures for 1950, based on a preliminary sample, show that 53,932,000, or 35.8 percent of our 150,697,000 population, are under 21 years of age. Of these young people, 12.1 percent are of races other than white. For the first time in any decennial census, more children were living in urban than in rural areas. The proportion in urban areas is 57.8 percent; in rural nonfarm areas, 22.9 percent; and on farms, 19.2 percent.

Child labor.—Over a million children 10 to 13 years of age—one out of eight youngsters of these ages—had jobs in August 1950. Even in October, a school month, 719,000 were working, or 1 out of 12.

This new count of child workers, made by the Census Bureau for the U. S. Department of Labor's Bureau of Labor Standards, includes children working in agriculture, and in stores, as newspaper carriers and sellers, baby sitters, and domestic workers.

Half these youngsters worked without pay, and many thousands of them for 35 hours or more per week.

Nearly two-thirds, 629,000, of the children with jobs were working in agriculture in August. In October, that number had dropped to only slightly less than a half million, 447,000. Of the 188,000 who worked for pay in August, 74,000 put in 35 hours or more per week. Unpaid agricultural workers 10 through 13 years old totaled 441,000 in that month, and 156,000 of these worked 35 hours a week or longer. Characteristically, these children worked on their parents' farms. Except for a small number of children classed as self-employed, no child was counted as working in agriculture unless he put in at least 15 hours in a week.

Farm clubs, India.—Two young people's farm clubs have been organized in New Delhi, India, under the sponsorship of the new "young farmers' movement." These are expected to be the nucleus of a national farm organization, much like 4-H clubs in the United States, to promote and develop an interest in rural problems.

GROUP WORK

(Continued from page 140)

their joining together. When the members of a group like each other, they create a climate that encourages the individuals to support and encourage one another.

The Y-Actives were such a group. The worker was aware of the good relations between the various members and strengthened these bonds through her own friendly, easy contacts with them, by helping each member take an active part in the meetings and encouraging the group to keep focused on its common interests and needs. She worked to give these young women the backing they needed to face their real feelings and desires. And with her encouragement they found that talking with one another frankly about the ups and downs of home life—of marriage, pregnancy, and child rearing—and filling the gaps in their information about these subjects lessened their anxieties and strengthened their confidence in themselves as wives and mothers. The social group worker's role, in general, was to create for the members the atmosphere of mutual appreciation.

Although the group worker never lost sight of the fact that it was the contact of one member with another during these regular associations that brought about results, she did use individual interviews as a supplementary tool in helping the members to achieve more satisfying family life. Opportunities came when she had to talk to the officers and other members about the duties they had accepted for the group. Unobtrusively she made opportunities to talk briefly with individuals in such a way as to encourage them to work out some of their difficulties. She interviewed such members as Mrs. O and Mrs. H by appointment in an effort to enable them to understand more clearly what was preventing harmony at home. She helped them to realize that they needed outside help to get things at home on an even keel, and she encouraged them to go to the specialized agency that could give them guidance. She kept in touch with their experiences with these agencies. This service required, of course, not only an understanding of individual needs, but interviewing skill and a knowledge of the other resources in the community.

Members learn from one another

In evaluating the group experience toward the end of the year, the "Y-Actives" said freely that the club had meant a great deal to them; that it had served as a retreat from the duties and difficulties of their home life and at the same time had helped them to handle these duties and difficulties more effectively. The club was a place where they could get sympathy and understanding from one another and from the worker. They had learned to do new things that interested them; they had drawn their husbands into the social part of their program, which helped to give the couples a social interest in common. It meant a lot to them to learn that other parents have troubles too and that a certain amount of stress and strain was normal and to be expected.

The agency, in reviewing its work with the group, concluded that it had fulfilled its purpose, to help members to find personal satisfactions through recreation and other programs in line with their interests and to help them meet their common problems and needs so that they might be able to participate more effectively in family and community life.

Thus, social group workers can use their skills—based on an understanding of how human beings behave and why, on the dynamics of group life, and on knowing about other services in the community that may be called on for cooperation—to assist young married couples in such a way that the quality of their family life brings satisfaction to themselves and provides a home atmosphere in which their children may develop healthy personalities.

Reprints in about 6 weeks

CLEFT PALATE

(Continued from page 143)

whereby a family will know at what age in the child's life each type of service should be given. Therefore careful and continuous follow-up measures with **local service registers** should be established through a local coordinating agency, such as the crippled children's services of a health department, so as to give the child continued care through the combined efforts of all the public, voluntary, and private community resources available. Because of the complex nature of the problem and the need for community coordination, the public agencies operating or supporting a cleft-palate program should make full use of competent technical and community advisory committees.

Because treatment takes so many years, and because the procedures, surgical and nonsurgical, usually have to be repeated again and again, the cost of correcting a child's cleft palate is prohibitive for most families. The burden of care therefore falls to a large degree upon public and voluntary agencies. And the complex battery of services required is as a rule too costly for voluntary agencies. Therefore, public funds are necessary for supporting community services for the restoration of children with cleft palate.

A public agency that carries on or supports a cleft-palate program should have adequate standards of service. Standards should be established for facilities and services in clinics and hospitals and for qualifications of personnel. A broad approach to the social and educational needs of the child is also an integral part of an effective program. If a public agency is to reach high standards in its cleft-palate program, it must pay high enough fees to professional persons and to hospitals and other voluntary agencies to obtain the desired high quality of service.

The community that does not give good service to its children with cleft palate is wasting dollars. Services that are rendered early and are well timed to the needs of the growing child prevent the development of conditions which would, if untreated, require still more services. For example, the child whose cleft palate has been improperly closed needs more speech instruction during his school years than if his defect had been properly corrected. Again, the child with improper or inadequate lip surgery or palate treatment needs more orthodontic treatment during adolescence. Whenever any step in service is rendered later than it should have been, more service is required. And not only is more service needed, but the results of rehabilitation are of course less complete. The patient's potential contribution to society is sharply curtailed, and the possibility of his becoming a drain upon the community in later years is increased. Inadequate care, in the end, costs the community much more than good care.

To summarize

We have listed and described the many ways in which the public, through Federal, State, and local agencies, is called upon to meet the rehabilitation needs of children born with cleft palate. The problem is not one for public agencies alone, but one for public agencies along with voluntary agencies and with individuals all joined in a community effort. The local health department has a great responsibility for coordinating community efforts to obtain for children with cleft palate complete rehabilitation and continued care, according to a rather well-established timetable. In a cooperative community program, specialized efforts for the child with cleft palate, in the form of establishment of a special clinic, with team training, should be balanced by strengthening general community resources — speech instruction in the schools, vocational training, job placement, and public education. Strengthening these services will benefit not only the children with cleft palate but also many other children.

Reprints in about 6 weeks

ADOPTION

(Continued from page 147)

whom adoption may be considered. Thus we are developing our adoption program more in proportion to the department's great responsibility to children.

No matter how well the adoption program of a public agency develops, no matter how liberal and flexible the department's decisions become on what children are adoptable, and no matter how resourceful the department grows to be in finding homes for children who might once have been considered unadoptable, the number of children placed for adoption will be small in proportion to the total number of children being cared for. Nassau County had, as of March 31, 1950, 1,072 children under care. Of this number, 727 were in boarding homes, 100 were in group care, and 37 were in adoptive homes. Though we hope that with the further maturing of our adoption program we shall have more children in adoptive homes under supervision a year from now, the disproportion between the number in this group and the number in other kinds of foster care will probably continue.

This is as it should be, we believe, in view of the basic principle of child-welfare work, that no child shall be deprived of his own family unnecessarily. The great majority of children who are in boarding homes and institutions are still bound to their parents by both emotional and legal ties. While we would acknowledge that many children have been "lost" in the care of public agencies—those children we have spoken of for whom agencies failed to consider adoption until too late — we would also insist that an agency can serve children best by helping their parents to carry the responsibility of parenthood to the fullest degree of which they are capable. This is certainly the opposite of placing children for adoption.

Reprints in about 6 weeks

To remind you—

Each year, according to law, the Federal Security Agency sends each person on the official mailing list for **The Child** a postal card asking whether he wishes to continue to receive it.

When you receive such a card, be sure to answer it, if you want your name to be kept on the list.

• FOR YOUR BOOKSHELF

THE NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE PRESENTS CHIC YOUNG'S "BLONDIE." Albany, N. Y. 1950. 16 pp. Available to recognized agencies and organizations interested in the promotion of mental health.

To the New York State Department of Mental Hygiene, a big bouquet for letting a beloved comic-strip family show us how it handles some of its mental-health problems. Flowers to the producer of this new type of comic book, too, who shows such real understanding of the booby traps that lie in wait to snare unwary family members.

Loud and continuous have been the laments going up over the scarcity of materials through which ideas, as well as information, can catch the attention of those who do their reading on the run, or in the subway.

How to reach people who can't be induced to plow through lengthy treatises on how to make their marriages and their children happy has wrinkled many a brow. This new approach the New York State Department of Mental Hygiene is using is anything but solemn, and it is all the sounder for it. And in the episodes in which Blondie and Dagwood and their children tangle with human relationships, every reader will recognize himself a lot quicker than he would in textbook case histories, and will have his risibilities stirred, instead of feelings of guilt.

"In utilizing this sprightly medium," says Commissioner Newton Bigelow, "we hope to reach the same public that is reached by comics in general — cutting across all social and economic strata and embracing every age level." We hope there will be such a wide demand for this effective, sharp-as-tacks educational device that many others as delightful will follow.

Marion L. Faegre

THE CHILD WITH CEREBRAL PALSY. Federal Security Agency, Social Security Administration, Children's Bureau Folder No. 34, Washington. 1950. 13 pp. Single copies free.

The outlook for the Nation's 175,000 children with cerebral palsy is brighter today than ever before. Not long ago cerebral palsy was looked on as hopeless. Now help is being brought to more and more of these youngsters, says this new booklet.

A growing number of communities throughout the country have public-health clinics and special facilities that provide the care needed by cerebral-palsied children. Schools are providing increasingly for these children through special services. And parents of cerebral-palsied children and children with other crippling conditions are working together to get the needed services for their children.

Prepared especially for parents of children with cerebral palsy, the booklet says the disease is caused by damage to the brain — either before birth, at birth, or after birth — and brings about poor coordination of the muscles of the face, the throat, the arms, the legs, or other parts of the body.

Children with cerebral palsy, the booklet emphasizes, are not necessarily feeble-minded, as some think. Although some are mentally deficient as a result of cerebral palsy, some are very bright. If these children are in a good program of care and have opportunity for suitable education, many of them develop intellectually as other children do.

Cerebral palsy is not inherited, nor is it contagious, the booklet says.

Like all children, cerebral-palsied children learn a great deal from being with other children. So parents of children with this condition should not isolate and overprotect them, the booklet cautions, but should encourage them to play with other children, to attend school, and to do as much for themselves as they can.

A limited supply of "The Child With Cerebral Palsy" is available without charge from the Children's Bureau. Copies may also be purchased at 10 cents each from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

ADOPTION LAWS IN LATIN AMERICA. By Anna Kalet Smith, Federal Security Agency, Children's Bureau, Publication No. 335, 1950, Washington. 34 pp. 15 cents. Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies may be had free by writing to the Children's Bureau.

With the growing importance of adoption as a child-welfare problem, the demand has been increasing for information on adoption laws in foreign countries. This bulletin, planned to acquaint the public with the laws of Latin America, contains the history of adoption legislation in Latin America since the Colonial period, an analysis of the present laws, and translations of those now operating in 15 Latin-American countries.

YOU AND YOUR HEART; a clinic for laymen on the heart and circulation. By H. M. Marvin, M. D.; and T. Duckett Jones, M. D.; Irvine H. Page, M.D.; Irving S. Wright, M.D.; and David D. Rutstein, M.D. Random House, New York, 1950. 306 pp. $3.

Written for the layman, this book includes information about the major types of heart disease, including rheumatic fever and congenital heart disease.

CHILD ANALYSIS NUMBER OF THE PSYCHOANALYTIC QUARTERLY, 1935. Reissued in 1950 by the Psychoanalytic Quarterly, Inc. 57 West Fifty-seventh Street, New York 19, N. Y. $5.

Fifteen years after it was first published, this collection of papers concerned with the analytic approach to children still stands as an important contribution. The problems in applying analytical knowledge in the education of children are just as pertinent and important today; and the dilemma of the child analyst in relation to the parental environment of the little patient, discussed by Burlingham, has not yet been resolved in a completely satisfactory way. Several of the clinical studies may be regarded as classics in the field of child analysis. We may be grateful that they are now easily available in this reissued edition.

The authors included are Anna Freud, Siegfried Bernfeld, Anni Portl, K. Pensimus, Erik Homburger, Dorothy Tiffany Burlingham, Berta Bornstein, Anny Angel, Edith Sterba, Edith Buxbaum, and Steff Bornstein.

Betty Huse, M. D.

INFANT NUTRITION; its physiological basis. By F. W. Clements, M.D. Williams & Wilkins Co., Baltimore, 1949. 246 pp. $4.50.

Modern knowledge of infant nutrition, gleaned from the literature of many countries, is assembled in this book in orderly and interesting form. Basic data on metabolism, physiology, and the properties of specific foods are given, followed by practical interpretations in terms of nutritional requirements.

A brief chapter is devoted to tissue metabolism, and four are concerned with fetal nutrition. Postnatal nutrition is dealt with under the following headings: The chemical and physical properties of human and cow's milk; Digestion in the young infant; Water metabolism; Energy requirements; Requirements of nutrients; Application of the principles; Disturbances of metabolism of dietetic origin.

The author has shown great skill in thoroughly documenting the material presented without letting this interfere with easy readability. The extensive bibliographies following the chapters indicate the wealth of material on which he has drawn and provide a valuable source of references for those wishing to consult the original literature.

Marian M. Crane, M. D., and Helen Stacey

OUR COOPERATIVE NURSERY SCHOOL. Silver Spring Nursery School, Inc., Silver Spring, Md. Revised edition. 1949. 100 pp. $1.50.

This second manual of the Silver Spring Nursery School, Inc., which was organized in 1941, is planned for the information of the members of the cooperative association that administers the nursery school and of the many persons who have visited and written to it — parents wishing to organize similar schools, other persons studying cooperative movements, students, teachers, and administrators interested in the nursery-school field.

The book explains in detail the organization of the cooperative nursery school, the duties of the mothers who participate in the work, and the relation of the school to the community. Finances, publicity, housing problems, business meetings, and annual meetings all come in for consideration. The appendix includes some useful guides, such as by-laws and forms, and rules to be observed when driving children to school and to their homes.

CHILD LABOR FACT BOOK, 1900-1950. By Florence Taylor. National Child Labor Committee, 419 Fourth Avenue, New York 16, N. Y. Publication No. 403. April 1950. 26 pp. 25 cents.

The early 1900's saw a rising interest in the child workers of the United States and an active concern about the conditions under which they were employed. This pamphlet, one of a series of child-labor fact books issued annually by the National Child Labor Committee, reviews that period and tells the changing story of child-labor conditions and social attitudes toward child labor during the past 50 years.

Devoting a section to each 10-year period, the leaflet gives the numbers and ages of working children at the beginning of the period, and facts about child-labor legislation, State and Federal, during that decade. It also traces the changes in public attitudes toward child employment and education. Census figures for young workers are given in a chart, showing differences from decade to decade in the composition of the young-worker force of the country.

The story of Federal action to control child labor is traced, from the first Federal child-labor law, declared unconstitutional in 1918, through the unsuccessful attempts to obtain a child-labor amendment to the Constitution and the child-labor standards of the NRA Codes, and finally to the child-labor provisions of the Fair Labor Standards Act of 1938 and the strengthening amendments enacted in 1949.

The extent to which individual State laws now accord with certain generally accepted standards is outlined. These standards are: a 16-year age minimum for all employment during school hours; a 14-year age minimum for employment outside of school hours and during summer vacations; maximum working time of 8 hours a day, 40 hours a week, and 6 days a week for boys and girls under 18 years; limitation of hours of part-time employment for boys and girls under 18 years while schools are in session; prohibition of night work for those under 16 years and those under 18 years; requirement of work permits for those under 18 years; prohibition of hazardous occupations for those under 18 years.

Ella Arvilla Merritt

INTERNATIONAL SURVEY OF SOCIAL SECURITY. International Labour Office, Geneva, 1950. 236 pp. $1.50.

A social-security system in a given country is a set of legal provisions creating specified benefits for specified groups of persons in specified circumstances. Social security includes, in the first place, compulsory social insurance — aided and regulated by the government—against the contingencies of illness, maternity, prolonged disability regardless of cause, unemployment, old age, or death of the family breadwinner; and, secondly, health services and other kinds of assistance made available by the government independently of social insurance. Voluntary insurance, if subsidized by the government, also is included.

The present survey, giving information on 45 member countries of the International Labour Organization, consists of two parts. The first contains an analysis of the main elements of the laws, such as contingencies for which benefits are provided, persons protected, definition of benefits, and organization and financing of social security. The second part, in which these elements are discussed by countries, includes (1) a table giving for each country the categories of persons protected and the contingencies for which benefits are provided, and (2) text, divided into sections, one for each of these contingencies; in each section a brief description of the nature of the benefits is given for each country.

Summaries, by countries, on the organization and financing of social security conclude the report.

This manner of presentation is helpful in mastering the intricacies of social security; but the numerous repetitions in the text are, to this reviewer, a hindrance in the process. Another inconvenience is the absence of complete summaries by countries, with dates of laws and references to the published sources, for the benefit of readers who are interested in the total situation in a particular country.

Anna Kalet Smith

EXPERT GROUP ON PREMATURITY; final report. World Health Organization Technical Report Series, No. 27. World Health Organization, Geneva, 1950. 11 pp. 10 cents.

Recommendations concerning babies born prematurely, drawn up by the Expert Group on Prematurity, of the World Health Organization, are presented in this pamphlet.

The group recognizes the necessity for uniform terminology concerning prematurity, for international use in programs for saving the lives of premature babies. And, in spite of the disadvantages in using birth weight as a criterion, the report suggests that a premature baby be defined as one whose birth weight is 2,500 grams (5½ lbs.) or less.

The group believes that consideration should be given to two types of program: (1) A preventive one directed toward lowering the incidence of prematurity; (2) a program for special care of infants prematurely born. The members agree that a country might be able to initiate one of these types of program before a complete program is developed, or it might start one or more local programs before making them country-wide. The requisites for each type of program, and the content, are given; and the development of a complete program is outlined.

The need for training physicians, nurses, and midwives, and for doing research in prematurity, is emphasized in the report. Lastly, the group recommends that WHO develop an information service on prematurity.

The members of the Expert Group are:

Dr. L. Camacho, Obstetrician; Chief, Maternal and Child Health Centre, Public Health Department, Quito, Ecuador.

Dr. V. Mary Crosse, Pediatrician, Birmingham Regional Hospital Board, Birmingham, United Kingdom.

Professeur M. Lelong, Clinique de Puériculture de la Faculté de Médecine de l'Université de Paris, France.

Dr. S. Z. Levine, Professor of Pediatrics and Pediatrician-in-Chief, New York Hospital, Cornell Medical Center, New York City, United States (chairman).

Miss E. Magnussen, Director, Nursing Division, National Health Service, Copenhagen, Denmark.

Dr. A. Ylppö, Professor of Pediatrics, University of Helsinki; Chief, Children's Clinic, Helsinki, Finland (co-chairman).

The adviser and the secretary are, respectively:

Miss D. Batt, Matron, Training Centre for Plunket Nurses, Dunedin, New Zealand.

Dr. Ethel C. Dunham, Consultant, Maternal and Child Health Section, WHO.

Alice D. Chenoweth, M.D.

YOUR CHILD MAKES SENSE; a guidebook for parents. By Edith Buxbaum, Ph.D. International Universities Press, New York, 1949. 204 pp. $3.25.

An enormous amount of information about the growth and development of children is included in this small book. Simply written and packed with concrete examples, it presents a way of looking at children and makes the point over and over that there is a reason for everything a child does.

To say that this book is "simply written" is not to say that it is simple to read. Dr. Buxbaum's point of view is based on "dynamic," analytically oriented child psychology, which, as Anna Freud says in her foreword, contributes to our understanding of "the inconsistencies, intricacies, and vagaries of childish behavior which had remained inexplicable until then." Many of the analytical concepts are so emotionally charged and novel to a great many lay persons that it is doubtful whether the majority of parents, for whom the book was written, would find it very useful.

On the other hand. some mothers and fathers who are eager to understand the new knowledge about the workings of their children's minds will find this book admirably suited to their needs.

For professional persons working with children Your Child Makes Sense should be a helpful and profitable volume.

Betty Huse, M. D.

Reprints Available

A limited number of copies of the following reprints from **The Child** are available for distribution. Single copies may be had without charge until the supply is exhausted.

Encouraging Initiative in Convalescent Children. By Maree Brower.

Fluoride Technique Demonstrated in Radio Program.

For the World's Children. By Ruth Crawford.

Harlan County Plans for Its Boys and Girls. By Amber Arthun Warburton.

Learning to Live Together. By Katherine Glover.

A Look at Our Training Schools. By Richard Clendenen.

Memphis Attacks Its Rheumatic-Fever Problem. By James G. Hughes, M. D.

Norway Improves Laws Protecting Mothers and Children. By Arnfinn Guldvog.

A Proposal for Joint Action Against Congenital Syphilis. By Betty Huse, M. D., and W. H. Aufranc, M. D.

Psychologist Can Help in Planning for Baby's Adoption. By Helen Rome Marsh.

• CALENDAR

May 1–7—Correct Posture Week. Sponsored by the National Chiropractic Association.

May 2–3—Society for Pediatric Research. Atlantic City, N. J.

May 2–5—American Pediatric Society. Annual meeting. Atlantic City, N. J.

May 2–8—National Mental Health Week. Information from the National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

May 4–5—American Council on Education. Annual meeting. Washington, D. C.

May 6–10—Boys' Clubs of America. National convention. New York, N. Y.

May 6–12—National Hearing Week. Information from the American Hearing Society, 817 Fourteenth Street, NW., Washington 5, D. C.

May 6–13—National Family Week. Ninth annual observance, by Protestant, Catholic, and Jewish groups. Information from Rev. Richard E. Lentz, 206 South Michigan Avenue, Chicago 4, Ill.

May 7—Fourth World Health Assembly. Geneva, Switzerland.

May 7–11—American Psychiatric Association. Annual meeting. Cincinnati, Ohio.

May 8–9—President's Conference on Industrial Safety. Washington.

May 9–12—United States National Commission for UNESCO. Annual meeting. (Previously meetings were held semiannually.) Washington, D. C.

May 13–18—National Conference of Social Work. Seventy-eighth annual meeting. Atlantic City, N. J.

Some other organizations meeting in association with the National Conference of Social Work:

- American Association of Group Workers.
- American Association of Medical Social Workers.
- American Association of Psychiatric Social Workers.
- American Association of Schools of Social Work.
- American Association of Social Workers.
- Big Brothers of America.
- Child Welfare League of America.
- Florence Crittenton Homes Association.
- Medical Social Consultants in State and Local MCH and CC Programs (May 12-13, 16).
- National Association of Training Schools.
- National Child Labor Committee.
- National Committee on Services to Unmarried Parents.
- National Probation and Parole Association.
- National Publicity Council for Health and Welfare Services.

May 14–18—General Federation of Women's Clubs. Annual convention. Houston, Tex.

May 14–18—National Tuberculosis Association. Annual meeting. Cincinnati, Ohio.

May 16–20—National Conference on Citizenship. Sixth annual meeting. Washington, D. C.

May 21–23—National Congress of Parents and Teachers. National convention. Miami Beach, Fla.

May 21–23—National Council of Juvenile Court Judges. Wilmington, Del.

May 21 - 25 — International Union Against the Venereal Diseases. Twenty - eighth general assembly. Paris, France.

May 23-26—American Association on Mental Deficiency. Annual convention. New York, N. Y.

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For most of the Midcentury Conference materials—

write to Health Publications Institute, Inc., Raleigh, N. C.

The five publications named below may be purchased as a "package" for $5. Also, quantity orders of the individual publications, except the proceedings, may be had at reduced prices.

Official White House Conference proceedings.—This book contains the recommendations of the conference; and the complete reports of the plenary sessions, of the 35 work groups, and of the information panels; as well as the major addresses and technical papers. 400 pp. Cloth, $4. Paper, $2.

Digest of fact-finding report.—Our readers are familiar with this digest; we published excerpts from it in a previous issue. 200 pp. $1. (The complete fact-finding report will be published in the fall.)

Conference platform.—This contains the recommendations adopted at the final plenary session; also the "Pledge to Children." 24 pp. 15 cents.

Pledge.—The Pledge to Children is presented on a scroll, of heavy paper, in three colors. 16 by 25 inches. 50 cents. Printed on lighter-weight paper, and smaller (12 by 18¾ inches), 10 cents.

Chart Book.—We have described this book before. Two of its 75 charts are reproduced in this issue; another one was in last month's. $1.

Two publications — the Report on State and Local Action (61 pp.) and the Report on Youth, National Organizations, and the Federal Government (122 pp.) — can be bought at 75 cents each from the White House Conference, Federal Security Agency, Washington 25, D. C.

The recordings of White House Conference Highlights, previously mentioned in **The Child**, can also be bought from the White House Conference. Each album, containing seven 16-inch double-faced records, $10.

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HE CHILD

MAY 1951

CHILD HEALTH DAY, 1951

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

U. S. SUPERINTENDENT OF DOCUMENTS
JUN 12 1951

A Proclamation

WHEREAS the Congress, by a joint resolution of May 18, 1928 (45 Stat. 617), has authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day; and

WHEREAS it is recognized that our children embody our most cherished hopes:

NOW, THEREFORE, I, HARRY S. TRUMAN, President of the United States of America, do hereby designate the first day of May of this year as Child Health Day; and I call upon the people of each community of the United States, and all agencies and organizations interested in child welfare, to consider upon that day how, in the coming year, they may carry out the objectives of the Midcentury White House Conference on Children and Youth, held last year, to the end that all our children may grow in physical, mental, and emotional health, with faith in God and in the dignity of man.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this nineteenth day of April in the year of our Lord nineteen hundred and fifty-one, and of the Independence of the United States of America the one hundred and seventy-fifth.

Harry Truman

By the President:

Dean Acheson

Secretary of State.

A nursery center aims to explore and to stimulate and to enhance every child's capacities, and to help him adapt to group living.

DAY-CARE CENTERS AND NURSERY SCHOOLS HAVE THE SAME GOALS

MARY ELIZABETH KEISTER

"NO ONE can claim that every child needs nursery school, but no one can deny that every child needs nursery education." I agree with these words of Dr. George Stoddard, which I heard him say when I was a student of his, years ago. For education, including nursery education, by its very nature goes on under all conditions, whether in the school, the home, the church, the settlement house, or the day-care center.

I believe—and I am well aware that there will be individuals both in social work and in education who would quarrel with me on this point—that the basic objectives of our nursery schools and day-care centers are not different. Our means of attaining the objectives may differ; and the superficial needs of various groups of children, of families, and of communities may be dissimilar. But basic needs do not differ from child to child, from family to family, or from one community to another.

For this reason I wish we could get away from the terms "day-care center" and "nursery school" and could use a term that combines the protective aspects of the one with the educational approach of the other. This idea is conveyed in the title given by Winifred Y. Allen and Doris Campbell to their book, "The Creative Nursery Center."

Individual growth of first importance

The chief objectives, as I see it, that we set for the young child in relation to his nursery center, or nursery school, or day-care center, is the fullest possible realization of his capacities for development and growth. In my own thinking I try not to lose sight of two aspects of individual growth: (1) Exploration, stimulation, and enhancement of the child's capacities, and (2) his gradual adaptation to group living and to society's demands.

All too often in the past the needs of the children have been subordinated to those of others. The peculiar needs of research centers, of

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Mary Elizabeth Keister is Professor of Child Development at the College of Home Economics, University of Tennessee, Knoxville.

Miss Keister received her Ph.D. degree in education from the University of Chicago, and was a teacher of the youngest group of children in the nursery school.

This article is based on the paper Miss Keister gave at the seventy-seventh annual meeting of the National Conference of Social Work, at Atlantic City, N. J.

teacher-training institutions, of working mothers, and so forth, have sometimes dominated our programs for children, and the children themselves have been shoved into the background. It seems to me that a children's center needs a period of development in which those responsible for the center look first at the needs of the children, and plan facilities, personnel, and program from that vantage point.

What good nursery education can do

Some of the things we have learned about children over the past two decades through observing them and teaching them, through clinical experience, and through research have caused us to change our goals and our programs for nursery centers.

For one thing, we have pretty well finished with our stiff-backed notions of habit training. We see that the lessons of independence and self-reliance need not be imposed so early, and so we have discarded our outworn ideas that the child must cry it out alone, must have his hurts minimized unsympathetically, must learn, at an early age, to put away his toys, hang up his coat, and dress himself.

Now we believe that psychological strength is based on the child's experience of warm, affectionate, protective contacts with adults. For the first 5 or 6 or 7 years of his life a child needs to be thought of, not as a plastic creature to be molded to fit the demands of his family or his culture, but as a person of conflicting feelings and of strong and often imperfectly controlled impulses.

We believe that a child needs the comfort of feeling that he will not be expected to control his own impulses alone and unaided; that adults will exercise control over him, but while controlling him will not hurt him or dislike him for his inconsistent and often distressing behavior. We believe that a child needs adults who will give him ways of releasing his strong feelings but at the same time will protect him—and also other people — from the consequences of those feelings.

We are beginning to realize further, that even if we can convince a child in the first years of his life that he is loved and valued and understood, we owe him much more than that. A child does not live and grow by love alone. As he grows he needs to free himself gradually from the infantile gratification of dependency and protection. He needs to like the idea of growing and of being grown-up. He needs opportunities to explore, to discover, to solve problems, to create. He needs the kind of experiences that will heighten his sensitivity, enhance his curiosity, lessen his confusions, promote the growth of his skills, and increase the range of his interests.

Good nursery education helps to ease for the child under 5 or 6 some of the strains associated with living and adjusting in our modern civilization. For 25 years and more, day nurseries and nursery schools have been giving thought to the question of what constitutes a good life for a little boy or a little girl, and many of our centers are offering convincing demonstrations of how that "good life" may become a reality.

We were not long in seeing that the young child must have all that good physical care can mean for wholesome growth—adequate food; a sufficient quantity of rest and sleep; stimulation of active play; a safe place to run and climb and dig and yell; watchfulness against accidents and physical hurts; protection against communicable diseases; and observation so that defects in physical functioning do not go long unnoticed.

To give children what they need

The good nursery center attempts to offer its pupils everything that mental hygiene has taught us children need—a feeling of belonging; success and praise; friendliness; a chance to participate in the life of a group; control and discipline; affection and approval; steadiness and consistency; respect from adults so that children can develop respect for themselves and for others.

When we reflect upon the number of children in all classes of our society who are neglected, or who are trained under fear of punishment, with little or no experience of deep affection and love, we may well imagine that perhaps the most important service the nursery center can offer to little children is mothering. By "mothering" we do not mean babying or pampering, but rather giving the child the opportunity to experience the feeling of being liked and wanted, of belonging to someone who cares very much what he learns and what is happening to him, and of being guided in the conduct of his affairs with benevolent support.

These things, we know, can be supplied only by persons who understand the depth, as well as the breadth, of children's needs. In preparing themselves for their work such persons gain not only broad and basic factual knowledge about children, but a sensitivity to its implications in children's emotional life. With this insight they are able to give of themselves in a way that both shelters and strengthens the children in their care.

Only with the opportunity to form deep attachments to adults can the child, I believe, take real advantage of what the nursery group can offer to satisfy his educational needs. Nursery centers believe also that young children must have a rich environment in which to grow and learn and all the while lead a life that is suitable for a child.

Hence, children who attend a "creative nursery center" should share in all that good teaching can mean—a variety of toys and playmates and games; the challenge of equipment and companionship under the guidance of an informed adult who knows how to make experiences meaningful, challenging, and pleasurable; the stimulation of books and pets and music and painting and excursions and science, all at the child's level; help in gradually broadening their ideas and concepts as well as expanding their concrete experiences.

Of course, chief among the young child's educational needs is his need for help and support in learning to build constructive relationships with other children. How to help children build friendly, cooperative attitudes is one of the critical issues of nursery education, it seems to me.

We need methods of handling situations in such a way that the initial hostility or aggression of the child may be rendered unnecessary by opportunities for friendly, helpful responses. Many children have had no experience of cooperative behavior and need the skillful guidance of an adult to encourage them in friendly conduct and sympathetic actions.

Children in a nursery center gradually adapt themselves to the demands of group living.

We do not know enough yet about how to meet wisely the problem of resentment and hostility and aggression in children. A policy of restraint or coercion or "sweetness and light" (which often is essentially repressive) may prevent fighting and disorder, but it probably does not relieve the child of the inner tensions and frustrations of which his behavior is but a symptom. Wholesome social growth is probably not achieved by a repressive policy, nor by permitting children to "fight it out."

What is needed is an imaginative, insightful handling of quarrels and aggressions, by an adult who sees them in the light of the feelings of guilt, anxiety, and frustration that underlie such behavior. But what is important is that such handling must mean to the child reassurance, support, tolerance, and sympathetic understanding.

Lawrence Frank has pointed out that the process of identification in which the child strives to emulate an admired and loved adult makes the teacher-child relationship one of enormous potentialities for either good or ill.

What makes children hostile?

Lack of sympathetic understanding, a withholding of tenderness and patience, may turn children toward hostility and aggression. And such deprivations in early childhood may be the cause of distortions in character from which children can be reclaimed later, if at all, only through long and difficult therapy.

Let us turn next to consideration of the objectives of the nursery center as it relates to the families it serves.

It is not sufficient, it seems to me, that group experience should benefit children only. Another of the functions of the nursery center is the stabilizing, facilitating, and enhancing of family living. Those responsible for either nursery schools or day-care centers have never viewed their function as that of replacing or supplanting the family. Indeed, if we had, the great weight of evidence accumulated in recent years would have forced us to change such an attitude.

For we believe now, more firmly than ever before, that there is no substitute for family life. And the experience of living in a family is so necessary to ordered personality development that we are almost forced into the attitude that the value of the nursery center may be measured in terms of whether or not it does stabilize, facilitate, and enhance family living.

Even a family judged "undesirable" by many of our standards can and does provide the child with a place, with status, with "belongingness." And a family we consider good offers the child, in addition, much-needed love, affection, and acceptance. The nursery center must organize its procedures and train its personnel to meet these same needs of children and also to provide for other educational needs, which the family has more difficulty in supplying.

In numerous and quite obvious ways nursery centers may be seen as making their contribution to family life today. Frequently an improved relationship between mother and child results from the child's attendance at a nursery group during part of the day. Mothers and children, we know, are likely to remain better friends when they are not constantly together. The nursery center helps to conserve the family when it makes it possible for the mother to work outside the home in order to keep her children together, or her whole family, or in order to raise the living standard of her family.

A nursery center can assume that it is not only children who have educational needs but that parents also have such needs. Many a parent who enrolls his child in a nursery anticipates that he, or she, will have some opportunities for learning to be a better parent. Fathers and mothers seem increasingly willing to seek help in educating their children in the early years and to rely more upon guidance. They frequently wish to help in evaluating theory in terms of how it can really be applied to their own children. In response to this demand, many centers for children of preschool age set up a parent-education program, making available to parents such resources as discussion groups and lectures, a library with suggested reading lists, opportunities for observing how skilled teachers deal with children, personal conferences planned to help in preventing, or at least in working through, a few of their problems.

Nursery center can set an example

It is true that a too aggressive parent-education program has its dangers, and the nursery-school teacher has been accused of rushing in where a psychiatrist would fear to tread. Overzealous efforts at "educating the parent" can stir up parental conflicts and create mistrust and hostility toward the institution making such efforts.

The most effective approach to the parent, it seems to me, is indirect and noncoercive. A good nursery center functions effectively in parent education when it merely demonstrates its way of thinking about children, its way of living with them and dealing with them. A fine example, we have long known, is one of the best methods of teaching.

The most effective aid we can count on in interpreting our program and in extending wider educational opportunities to our youngest citizens will come from parents themselves. Thus, a worthy objective for the nursery center involves helping parents to understand its viewpoint and philosophy. And this we should try to accomplish, in concrete terms of what it means to children and to families to be associated with a vital and creative nursery center.

And now, lastly, let us formulate briefly the objectives of a nursery center in relation to the community that it serves. There is hardly a community in this Nation that does not recognize the importance of a program of preventive medicine for its children, and many communities have in action broad health programs for children. But not only does every child need such things as immunizations and a complete diet to help him to build a healthy body, but also he needs social experiences to help him build a strong and creative personality.

We know already many of the things we want for our youngest children in the future. The nursery center, then, might spearhead a campaign, maintaining that a program which is good for *some* children could in time be made available to *all* children. The best centers would look on themselves not simply as the finest places for all the children in a given community who are ready for group experience, and their parents, but rather as institutions that demonstrate what good nursery services can do for children and their families everywhere.

We must avoid, of course, giving the impression in the community that the nursery center furnishes the one best answer to the needs of children and is our hope for the future. Instead, we should continue to regard the family as of crucial importance and see the need for nursery centers in the perspective of family life. And we should seek always to evaluate the centers according to the degree to which they strengthen family life.

If the nursery center is to be coordinated with other community organizations and services, its philosophy and program must be understood by citizens. One step toward such coordination is the recommendation of the White House Conference that nursery schools be included as part of public educational opportunity for children.

Citizens themselves are not standing still. They are taking the lead in many places, by such means as forming community councils aimed at coordination of community interest. As Dr. Ernest Osborne has recently pointed out, it is only by the combined efforts of professional and lay groups that we can reach large numbers of the public, and overcome some of the barriers to citizen appreciation of children's educational and social needs.

It is wholesome for members of any profession to have to justify their attitudes and practices to laymen. Through the necessity to interpret and defend our programs to the lay public, we avoid sterility and the all-too-human tendency of any profession to look upon its policies and its thinking as sacred and not to be questioned by "outsiders."

For the future

It is always easier to say what we ought to be doing for children than it is to point out just how such programs may become a reality. These will cost money, and many communities will be all too ready to turn a deaf ear to demands. But I believe we would not want the kind of community interest and support that is based on superficial enthusiasm or on slogans with an appeal to one group or another. What we must stress constantly and try to show in our centers are the enduring values to the child and to the community that arise out of preschool group experience. In the last analysis, the best interpretation of any need lies in the worth of the program designed to meet that need. And staunch support will come to us out of the conviction of those working in this program that the hope of our world lies in whatever can be done in the next decade or two for our youngest citizens. This is for the future, but it is not too early to make the blueprint.

The nursery center can demonstrate, through its program for children and their families, how it is possible to approach that ideal—that of the richest, freest country in the world—a generation of children who are healthy and happy and creative, who have had an opportunity to play and learn and grow in an atmosphere of well-being and high morale.

Reprints in about 6 weeks

NEW HAVEN HOSPITAL OFFERS EDUCATION FOR CHILDBIRTH

HERBERT THOMS, M.D., and EDWARD FOORD, M.D., New Haven, Conn.

TODAY in our country infant and maternal mortality are lower than was thought possible by pioneers in antenatal supervision early in the century. No doubt many factors have joined to save the lives of mothers and babies. For one thing the present-day high rate of hospitalization for delivery, almost 100 percent in some States, represents a remarkable change from conditions even a generation ago. How much this increased use of hospitals has brought about the greater safety in childbearing can only be conjectured, but there is every reason to believe that the correlation is close.

At the same time a wide public interest has developed in the whole subject of childbirth and parenthood. Prospective mothers and fathers especially desire information and guidance. This attitude is widely reflected in the press, and especially in popular magazines. On the whole, the wide influence of these sources of information has been progressive and wholesome.

The importance of wider recognition of this desire for information and guidance has become increasingly clear to us as, over a 4-year period, our program of training for childbirth has developed under the auspices of the Yale University School of Medicine at the Grace-New Haven Community Hospital (University Service). As a result we now consider our program as essentially *training for parenthood;* a cooperative effort in education, in which nursing, pediatrics, and psychiatry contribute significantly to the success of the obstetric program.

Physical safety for the child is one of the aims of a program of education for childbirth.

This training program has become known rather widely as a "natural childbirth" program, in a way an unfortunate label, for some writers in popular publications have considered the term synonymous with painless childbirth, or as childbirth without anesthesia. Others have thought it meant childbirth according to primitive practice, and in spite of opposing evidence have assumed that it is, therefore, painless. Unfortunately, too, some physicians, without full information, have misunderstood the aims of the program.

Because of these misunderstandings, we repeatedly emphasize that our program is primarily educational. We do not aim primarily to conduct labor and childbirth without analgesia or anesthesia. We believe the program is wholly consistent with scientific obstetrics. In addition, it eliminates to a significant degree the hazards to mother and child associated with the use of heavy sedation and it makes childbirth a more satisfactory emotional experience.

Our program emphasizes that childbirth is a natural, normal process, and that it is important for the prospective mother to recognize that bringing a baby into the world is a cooperative endeavor in which

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Dr. Edward Foord is resident physician on the obstetric service at the same hospital, and he is instructor in Obstetrics and Gynecology at the Yale University School of Medicine.

This paper has been prepared in shortened form from a paper by Drs. Thoms and Foord, entitled "Public Health and Education for Childbirth," presented at the meeting of the Division of Health Services, Children's Bureau, Federal Security Agency, Washington, D. C., March 21, 1951.

she plays the principal role. It also represents an effort on the part of physicians and nurses to gain further understanding of the physiology of childbirth, particularly in its emotional aspects, so that their assistance in pregnancy and labor can be intelligently applied.

We aim to make each labor experience psychologically and emotionally satisfactory, one that is at the same time physically safe for both mother and child. Our experience tells us that a conscious delivery can be the source of a great sense of achievement for most women. We believe that, if the labor is normal and properly conducted, and the woman has been prepared for the experience, much of the usual pain is not experienced and only small amounts of medication are necessary. We do not contend that relaxation alone will prevent all the pain, nor do we believe that pain is in any sense a desirable or beneficial part of the childbearing experience.

In carrying out these aims we attempt to prepare a woman for childbirth psychologically and physically through teaching her about the anatomy and physiology of reproduction, by training her to relax and to control her muscles so that she can aid the natural forces of labor. During labor she is encouraged, by those in attendance, to use this knowledge and training.

The educational aspect of our program consists of four talks given to prospective parents by a physician and four exercise classes given by a nurse.

In the physician's talks the subjects of pregnancy, labor, the newborn, and parenthood are discussed by members of the obstetric, pediatric, and psychiatric medical staffs. The talks are given in the evening for four successive weeks, four times during the year, being so arranged that husband and wife will attend the first talk early in pregnancy and the last three during the last three months. These talks have been very popular, and interesting discussion periods always follow.

The nurse, in addition to training the women in relaxation techniques and breathing exercises and giving them postural exercises, tells about various aspects of pregnancy and labor. Group discussion is encouraged. After the fourth class, which is given in the third trimester of pregnancy, the women visit the obstetric division of the hospital, meet members of the personnel, see the labor and delivery rooms and the anesthesia apparatus. Between classes the patients practice the exercises at home.

Childbirth is a natural process, and it is important for the mother to recognize that bringing a baby into the world is a cooperative endeavor in which she plays the chief role.

Woman in labor needs support

We recognize that "support" during active labor is the most important single factor in our program. Much depends not only on the sympathy and interest of those in attendance, but upon a true understanding of the reasons for the educational program and the details of it. Final success depends on physical factors, such as normal labor in a healthy woman, in whom there is no disproportion between the head of the fetus and the mother's pelvis and no abnormal position of the fetus; in whom the soft parts are normally dilatable, the uterine contractions are of proper regularity and of suitable force, and the patient's delivery is without undue strain on her part.

In labor support we follow several principles. The patient in labor is in a room by herself and during this period she may have her husband with her if she wishes. The patient is kept informed of her progress, and during active labor is not allowed to be alone. Attention is focused on her needs and on what she is trying to accomplish. Any therapy or instruction is in the hands of a nurse or a physician. Activity and busyness on the part of those attending her are kept to a minimum. Removal to the delivery room is deliberately timed so that plenty of time is available for preparation. The husband is not allowed in the delivery room. Further details of our program may be found in references 1 and 2.

Results summarized

A brief summary of the results of 1,000 deliveries may be of interest [3]: Of these mothers, 779 were ward patients and 221 were semiprivate or private patients. There were 12 pairs of twins and one set of triplets. All but 86 of the infants weighed more than 2,500 grams and were therefore not considered premature. Three hundred and seventy-five mothers were having their first babies, and 292 of these (78 percent) had spontaneous deliveries. Of the 625 who had previously had one or more babies, 589 (94 percent) had spontaneous deliveries.

The small amount of analgesics (drug medication) and of anesthetics needed was noticeable, especially among the mothers who were delivered spontaneously.

Of the 292 such mothers delivered spontaneously who were having their first baby, three-fourths required little or no analgesia and 58 of these women required none. Ninety-five percent required but small amounts of anesthesia.

Of the 589 who previously had had one or more babies, and delivered spontaneously, an even larger proportion did not require the help of analgesics or anesthetics.

On the whole, the labor period for all the women was shorter than is usually given. The average length of labor for the mothers of first babies was 14 hours; for the mothers who had had babies before, it was 8 hours.

A favorable record

There was no maternal mortality. Four of the babies died before birth, four during birth, and four within a week after birth, all from causes ascertainable.

We believe that the small amounts of analgesics and anesthetics required have contributed to this favorable record and also that the relatively short duration of labor is related to it.

In addition to our interest in preserving the health of mother and baby, we have deep interest in certain psychologic results, which, though not so readily appraised, are important. In this connection we would emphasize that the rooming-in arrangement for mother and baby is an integral part of the program. Unfortunately these accommodations are limited to 8 beds, altogether too few for our demand.

All questions concerning the desire for rooming-in, for maternal nursing, for presence of the husband during the labor period, and the like are decided by the mother herself.

We do not consider that our program is anything very new. Twenty years ago Dr. John J. Fairbairn, eminent in British obstetrics, wrote: "It can safely be said that if the practitioner can succeed in getting his patients to respond to the education given in the antenatal period he will increase his proportion of natural deliveries. By removing fears and anxieties and instilling in their place confidence in their power to see the business through themselves, some may be stimulated to follow the example of their maternal forebears and do with as little adventitious aid in labour as they had."

Nor is the idea of mothers' classes new. In the New Haven area, for some years, both mothers' and fathers' classes have been conducted by the Visiting Nurses Association and the New Haven Health Department, with the cooperation of local physicians. The work of the Maternity Center Association in this field in New York City is well known. And it is certain that our own program could not have been developed to its present state without the important aid of the Maternity Center Association.

All these efforts represent an excellent start toward wider recognition of the importance of education for childbirth. However, we believe that there should be a further development in hospital maternity care through a more adequate appraisal and support of the labor process and a deeper understanding of the emotional needs of parturient women.

For emotional needs of obstetric patients

Many women today are expressing resentment at methods involving heavy sedation; many also resent the treatment accorded them in the common labor rooms of many hospitals, where the lack of privacy leaves much to be desired. We believe that more attention should be paid to the fact that obstetric patients are not sick patients and that their emotional needs before, during, and after hospitalization are totally different from those of any other patient group.

The centering of the program in the hospital is in line with present emphasis on making hospitals more efficient as community health centers.

Program is adaptable

It has been conjectured by some that the type of program that we have outlined here is only possible in a teaching or similarly well-integrated obstetric service. However, we have first-hand knowledge that many practitioners are successfully adapting the essential elements of the program to their obstetric practice. Indeed, the first report of this type of program in the United States was that by a general practitioner, Dr. Blackwell Sawyer of Toms River, N. J., in 1946.

Many people appreciate the values of education for maternity so ably emphasized by Dean Millicent McIntosh of Barnard College at the International and Fourth American Congress on Obstetrics and Gynecology, who said, "The skill and experience of the doctor and the man of science should in some way be interpreted more clearly to the layman, through greater understanding and closer cooperation between the teacher and the physician, and of both with the individual. . . If physicians and educators work together, they will recognize that preparation for maternity is the most important task of our society."

1. Thoms, Herbert, M. D.: Training for Childbirth; a program of natural childbirth with rooming-in. McGraw-Hill Book Co., Inc., New York, 1950. 114 pp.

2. Thoms, Herbert, M. D., in collaboration with Laurence G. Roth, M. D.: Understanding Natural Childbirth; with a picture story by David Linton. McGraw-Hill Book Co., Inc., New York, 1950. 112 pp.

3. Thoms, Herbert, M. D., and Robert H. Wyatt, M. D.: One Thousand Consecutive Deliveries Under a Training for Childbirth Program. American Journal of Obstetrics and Gynecology, vol. 61, No. 1 (Jan. 1951), p. 205.

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WHEN A CHILD HAS POLIO

Community resources can contribute to the patient's recovery

ELIZABETH MAGINNIS

WHEN a child has polio, he needs not only the treatment that the doctor, the nurse, and the physical therapist provide; he needs also protection from the emotional hazards of a long illness. Perhaps the greatest of these hazards arises out of the necessity of being away from his mother for a long time. Such separation may have a damaging effect on a child, in sickness or in health. Just being away from his mother and the rest of the family, which is often necessary as part of the first phase of the treatment of infantile paralysis, may injure a young patient lastingly unless something is done to minimize the shock.

Even with well children—young in age or in emotions—wise parents plan ways of preparing them for relatively brief family separations. For emotional difficulties are not likely to arise if the child has accepted in advance that the parting is necessary.

To keep the child in touch with home

To keep a child and his family in as close contact as possible when he has polio and is in a hospital, or when he is convalescing, calls for thoughtful planning. During the intervals between his mother's visits, ways may be found to help even a young child to feel that he still has her close, loving attention. Older children too, who are beginning to break away from complete dependence on their parents, need to be in frequent touch with their families while they are sick, and need to feel that they are being missed at home. Helping to maintain these contacts and to make possible these assurances of affection is one of the services in a hospital that supplements the child's medical care.

But the actual reunion of child and family as quickly as is consistent with good medical care is the aim of all that is done for a boy or girl who is away from home because of illness. To help bring about this early homegoing, workers within the hospital call into action health and social-welfare resources outside the hospital. Many communities have a variety of agencies that can give invaluable service of this kind and most communities offer at least one of the many possible services.

A link must be forged, however, between these agencies and the child who has polio. Someone on the hospital staff who knows the child's situation and also knows the potentialities of the community's resources to help him and his parents is the logical liaison. This forger of the link is more than an intermediary; she not only knows the facets of the child's needs, and what services the agencies have to offer him, and how to bring them into play, but she also knows how to get the patient ready for the services. She appreciates what steps are necessary in his progress before outside assistance can benefit him. In other words, this staff member has the skill to help a patient—even a very young one—to understand the next move after his own fashion and to feel ready to take it. This readiness of the child is one of the elements that make for success in the whole plan for restoration.

In many hospitals the worker who coordinates services for a child with polio, both inside the hospital and outside, is the medical social worker. Working with other members of the medical team, she helps the parents in their first contacts with hospital routines, which are likely to bewilder them. She gets answers to many of their questions, or helps them ask the busy doctor questions that they have not felt free to ask him, or, that they have asked, but have failed to understand the answers. She learns whether they accept the doctor's recommendations and whether the parents have problems that will make it difficult or impossible for them to carry out the recommendations. At the request of the doctor, she finds out what he wants to know about the patient's background. She does her part, along with workers in other specialties, in preparing the family and the home for the patient's return. Just as she coordinates services for the patient's benefit within the hospital, she also coordinates them for him outside the hospital, as we shall see. This coordination of services is only one part of a medical social worker's duties, but it is one pertinent to a discussion of the community resources available to young infantile-paralysis patients.

One such child is Helen Martin, as we may call her, a 6-year-old living in a small city in a thickly populated Eastern State. (The program in this State for polio patients is not typical—no other State has one like it.) We chose this State as a background to show the use of community resources because it has a wealth of health and social agencies that have developed over a long period out of deep-rooted traditions. It was during an epidemic that

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Elizabeth Maginnis is the social worker in the Infantile Paralysis Unit of the Children's Medical Center of Boston.

This article is based on a talk given by Miss Maginnis in New York City to a group of State representatives of the National Foundation for Infantile Paralysis.

Home again, after a long time away from his folks, a little patient looks forward to the day when he will no longer need his crutches.

Helen became ill; what was done for her was done under the pressure of that situation.

We first see Helen when her mother is taking her from their home town to the children's hospital in their State's largest city. The hospital is also atypical; it is known and depended on by families all over the State and in adjoining States too. The hospital admitted between 500 and 600 polio patients that year.

The day Helen's mother took her to the hospital, Mrs. Martin had a bewildering series of experiences. She talked with an admitting clerk, a nurse, a doctor, a social worker, and a public-health nurse. The social worker arranged for her to see also a representative of the National Foundation for Infantile Paralysis, after explaining that the Foundation guaranteed payment to the hospital, for a limited period, of whatever costs the family cannot meet. (Meanwhile long-term plans can be made for meeting the complete cost of the illness.) Next, the mother saw the hospital credit manager.

While Mrs. Martin was at the hospital, she talked with seven persons, some of them more than once. She was confused by all this, although in the next few weeks she saw the seeming complexity form into a simple pattern of service with one end in view—Helen's recovery as quickly and as fully as possible.

When Helen's mother talked with the medical social worker that first day, she received answers to many questions and had a chance to speak of the things that distressed her. Like all parents of children with polio she feared that her little girl would not be able to walk again or that she would be greatly crippled. She also feared that Helen would be very frightened and lonely in the hospital.

The child was not in school yet, she explained, and was very shy with strangers. "Perhaps I have babied her too much—she's our only daughter," she said. "Our son—he's a real boy—is 6 years older than Helen."

Mrs. Martin was worried also because she had to have a major operation just at this time. Mr. Martin would have to keep at his job, she said. He was an automobile mechanic, earning moderate wages. They were buying a five-room house. They had no car. After talking with the various workers in the hospital, Mrs. Martin left with the feeling that everyone caring for Helen would try to keep her free from fear and loneliness.

It was not possible for Helen to be visited until 2 weeks had passed, because of isolation requirements, but the hospital arranged for Mrs. Martin to talk each morning over the telephone with Helen's doctor, so as to hear directly from him about the child's progress. She also telephoned to the social worker every 2 or 3 days. She asked especially whether Helen was getting used to being in the hospital and whether she had been unhappy. The worker told the mother of her talks with the little girl.

As soon as the social worker learned when Helen would be ready to leave the hospital, she started arranging for after-care. At the end of 2 weeks, Helen was taken to a convalescent home in the suburbs that had about 60 polio patients that summer. During the month she was there, the children's hospital social worker went to see her once a week.

Meanwhile, Mrs. Martin had an operation performed at a general hospital. Then the medical social workers (at the two hospitals) worked together so that separation by hospital walls of mother and little girl would not make them seem worlds apart. Helen's social worker was in touch with Mrs. Martin's doctor; she let Helen's doctor at the convalescent home know about the medical recommendations made for the child's mother, so that plans for Helen's discharge could be worked out in relation to Mrs. Martin's return home from the hospital.

When Helen's doctor decided that she was ready to go home, Mrs. Martin was not strong enough to undertake, in addition to her housework, the care of a child who was not yet permitted to walk and who required several kinds of help. She would need a breathing spell in which to get her energy back for the long pull toward Helen's recovery. The medical social worker told Mrs. Martin about the "homemaker service" provided by one of the local family-service societies and, at the mother's request, arranged for it. This agency would send to the home each day a woman from its staff to help Mrs. Martin in doing the housework and in caring for Helen. Mr. Martin agreed to repay the agency some of the cost, in accordance with his ability. The Martins could afford their share of the agency's expenses in this service in spite of the two recent illnesses because they had hospitalization insurance and because they had had some indirect financial assistance from the National Foundation for Infantile Paralysis. Thus they were saved from the full brunt of what would otherwise have been an expense too great for them to manage.

In addition to the homemaker service, the medical social worker saw that arrangements were made for the visiting-nurse association to send one of its physical therapists to the Martin home three times a week to help Helen with her exercises and to supervise the other therapy the child must have.

Soon Mrs. Martin began to take over her daughter's care. Later on, she also took Helen every 2 weeks to a local physical-therapy treatment center.

By this time Helen had become old enough for school. After getting permission from the doctor, the medical social worker arranged with the public-school system to provide a home teacher. This meant that Helen could keep abreast of the grade she would normally be in. About once a month Mrs. Martin took her daughter, with the cooperation of the Red Cross Motor Corps, for a medical check-up at the orthopedic clinic of the children's hospital where Helen had been during the acute stage of her illness. In 4 or 5 months, Helen could be admitted to this hospital's orthopedic ward for a week or more of instruction in walking.

Child's return home speeded

All this network of resources may seem unnecessarily complicated and time-consuming when one first hears about it. But use of these facilities made possible Helen's early reunion with her mother, her father, and her brother, and it helped to permit the two patients to become active in their own convalescent care early and naturally.

Unfortunately, not all communities have so many resources, and such well-developed ones, as this one has, but each State has an official State crippled children's agency that can arrange care for a child with polio. Suppose Helen had lived in a locality with few of the agencies that were called into play where she did actually live. What would the difference have been? The main contrast would probably have appeared in the much longer time that would have to elapse before Helen could go home, even though her doctor thought it was best for her to go.

Let us imagine Helen living in a county in a certain other State—a county that covers a large area; that contains a large city; that has a fast-growing population; and in which the incidence of infantile paralysis is high. The county has good hospital facilities, but it has comparatively few health and social agencies to supplement hospital care. In that county, as in the one previously described, Helen would have been sent from the general hospital where she was treated during the acute stage of her illness to a convalescent home arranged for by the hospital social worker or by a worker from the State crippled children's agency. The worker would have tried to arrange for an institution that would be convenient for the parents to visit without a car of their own.

So far, the course of events would have been about the same. But when Helen's doctor decided that the child was ready to leave the convalescent home for her own home, the lack of community resources would have blocked the logical next step. The right plan for the little girl would have been to return home and then attend an orthopedic clinic at suitable intervals. The home she was convalescing in had a clinic, but it met too infrequently for Helen's needs. It could have been arranged for a physical therapist to see the child at the hospital once or twice between clinic sessions. However, there would have been no way for the parents to get Helen to the clinic or to see the physical therapist—this was a transportation problem.

Besides, Helen's mother, just home after having an operation, would not have been in physical condition to give her daughter, who was not yet permitted to walk, the care she needed, and also to manage the Martin household. The neighbors were unable to help her. There was no way to get assistance for Mrs. Martin in this difficulty.

The only feasible plan would not be the best plan—for the child to stay on at the convalescent home. Even though the time stretched into 6 or 9 months, Helen would have had to stay there until she was allowed to walk and had had instruction in walking. Thus, the lack of services to supplement her medical care would have delayed the reunion of Helen with her family and would have added to the cost of her illness. How great an effect her being away from home so long a time would have on the child's emotional development is hard to judge.

Hospital helps child and parents

Although this is a discussion of sources of help outside the hospital, we should appreciate fully the fact that the hospital is a tremendously important resource for the child who has poliomyelitis and for his parents. But the help that hospitals can offer differs in adequacy for many reasons, and the amount of help they can offer to children varies proportionately. Not the least of these reasons is the number of other patients cared for at the time of a child's illness and the degree of involvement he has suffered. The work of restoration actually begins as soon as the doctor suspects that the child has polio, and it continues to develop as far as the treatment facilities of the hospital permit. Then the task must be passed on to the agencies equipped to provide other special services.

Earlier, we mentioned the part

If a child with polio is to get the special services he needs, many facilities must be used.

the medical social worker plays in readying the young patient and his family for the next step in the child's care, a step that was planned with the help of outside resources. Another factor we should emphasize is the patient's own efforts to get well. Extreme care should be taken not to give a child patient too much support, as this might prevent him from using his own power of recuperation to the full, and might thus defeat the whole aim of our service. Truly, the primary source of help for a patient of any age is himself; he is the one most affected by the outcome of his illness. The characteristics and qualities that he brings to this crisis and that he makes use of within the confines of the disease have a definite effect on the outcome of the care he receives.

The place of the medical social worker in this network of health and social-welfare services is not so well understood by the public as is the place of the doctor, the nurse, and the physical therapist. The medical social worker in the hospital is in a strategic position from which to assist the patient and those who are caring for him. She is a member of the medical team and works in collaboration with the physician, the nurse, and other therapists. She is aware, in general, of difficulties that are likely to arise and can frequently give appropriate services early enough to prevent the development of serious social problems.

To coordinate all resources

But the point of our discussion is her coordination of sources of help. The medical social worker must be well acquainted with what the community has to offer. She must know the health department; the State crippled children's program; voluntary crippled children's services; the schools; family and children's agencies; and all sources of vocational rehabilitation, private and public. In fact, she must know whatever agencies the community has that will lend a hand beneficially.

She must know how to use these agencies to the best advantage, which includes the element of time. Good timing is a fundamental skill that she shares with other professional workers, and that she learns from a variety of experiences. The medical social worker can learn much from watching the timing of skilled physicians when they deal with polio patients—judging just when to allow them to be dependent and just when to stimulate them to assume some active responsibility for their own care. Sometimes a child patient wants to go ahead too fast for his own good, and avoiding this is quite different from holding him back unnecessarily when actually he should be taking the next step.

The social worker, like the physician, must always be thinking ahead of the sick child and yet must not rush him, nor must she delay him when he is ready for something different. Often in our eagerness to have him fulfill *our* expectations, we are tempted to offer him too much too soon and too easily. Then the child may be disappointed; or we may blame him because he is unable to follow an action through, whether it is related to the medical care itself or is in connection with the assistance offered him by social and rehabilitative agencies.

That many skills are required to assist a child with polio is clear. With this disease it is a rare situation that requires the services of as few people as doctor, nurse, and physical therapist. Some of the characteristics of polio that call for a joint effort on the part of many kinds of workers are: (1) the infectious nature of the disease; (2) the fact that a severity of involvement can cause an extreme disability, requiring from the patient the adaptability necessary to create a good life for himself; and (3) the unusual length of medical care as compared with some other diseases; and (4) the residual handicaps that some children have, requiring rehabilitative services.

All the characteristics of poliomyelitis should be considered in treating a patient, whatever his age, and in making the most of community resources to help give back to him the opportunity of living his life fully.

Reprints in about 6 weeks

IN THE NEWS

Two new Associate Chiefs for Children's Bureau— Dr. Katherine Bain has been appointed Associate Chief for Program Development, and Melvin A. Glasser Associate Chief for State and Community Services, effective April 3, 1951. Dr. Bain's duties will include special responsibilities in relation to the health programs of the Children's Bureau.

Miss Neota Larson, who has been assistant chief of the Bureau since 1949, continues in this position.

After 13 years of practice in pediatrics in St. Louis, Mo., where she was born, Dr. Bain came to the Children's Bureau in 1940, as Director of the Division of Research in Child Development. In this position she was responsible for planning research, developing standards for child care, and supervising the preparation of bulletins and leaflets for parents.

Under Dr. Bain's guidance the Clearinghouse for Research in Child Life was established, at the request of research workers, in the Children's Bureau in 1949.

From 1945 through 1947 Dr. Bain was a member of the executive staff that designed and made the first Nation-wide survey on the extent of health services for children in this country. This study was undertaken by the American Academy of Pediatrics with the assistance of the Public Health Service and the Children's Bureau.

Dr. Bain received her certification in pediatrics in 1943 and in preventive medicine and public health in 1949.

During World War II, Dr. Bain helped in civil-defense planning, with emphasis on evacuation of children, day care of children of working mothers, planning for materials in scarce supply, and feeding in occupied countries. She was a member of the Technical Secretariat, United Nations Conference on Food and Agriculture, which was held in Hot Springs, Va., in 1943.

She is a member of the Committee on Child Development of the National Research Council; a member of the Child Health Committee, American Public Health Association; and a member of the Committee on Hospitals and Dispensaries of the American Academy of Pediatrics. She is also a member of the American Pediatric Society and is on the Board of Directors of the Society for Research in Child Development.

Mr. Glasser was born in New York City and completed graduate studies in education and social work there. He was associated with public and private welfare agencies in New York City until 1942, when he joined the staff of the American Red Cross. In the American Red Cross, he became Assistant Director of Civilian Relief, and later Assistant Administrator of Foreign Operations in charge of international-activities programs. In this connection, he made the first postwar Red Cross relief survey in Czechoslovakia, and he organized American Red Cross child-welfare activities in that country. In 1948 Mr. Glasser was a member of the American Red Cross delegation to the Seventeenth International Red Cross Conference in Stockholm, Sweden, and he made surveys of relief conditions in Germany, Austria, and Hungary. He was U. S. Department of State observer at the International Conference of Social Work in Paris in 1950.

For his work in relief activities abroad, Mr. Glasser was awarded the Order of the White Lion of the Czechoslovakian Government in February 1946. He has also been decorated by the governments of the Netherlands and of Denmark, and has had a special award from the Finnish Red Cross.

Mr. Glasser is one of the two U. S. representatives on the permanent committee of the International Conference of Social Work, and is a member of the Program Committee of the National Conference of Social Work. In July 1950 he was elected President of the International Federation of Social Workers.

Dr. Edwin F. Daily has resigned as director of the Division of Health Services of the Children's Bureau to accept appointment as deputy medical director of the Health Insurance Plan of Greater New York, effective June 4.

Dr. Daily was responsible, during World War II, for administering the Nation-wide program of Emergency Maternity and Infant Care (EMIC), under which more than 1,200,000 wives of servicemen received medical and health care during pregnancy and at childbirth, and more than 200,000 of their babies had medical, hospital, and nursing care when sick.

For a major portion of his 15 years' association with the Children's Bureau, Dr. Daily has directed that part of the Bureau's work which affords help to the States in extending and improving their maternal and child-health services and their services for crippled children.

Dr. Daily joined the staff of the Children's Bureau in April 1936 as consultant in obstetrics and gynecology. He served as Assistant Director and later Director of the Division of Maternal and Child Health before being named to his present post, becoming Director of the Division of Health Services in July 1941.

Dr. Daily is a fellow of the American Public Health Association, and a member of its subcomittee on medical care since 1944; a diplomate of the American Board of Obstetrics and Gynecology and of the American Board of Preventive Medicine and Public Health; and a member of the board of directors of the National Organization for Public Health Nursing.

He was a United States delegate to international health conferences held in Europe in 1938, 1948, and 1950 and a delegate to the First Inter-American Conference on Rehabilitation of Cripples, held in Mexico City in 1948.

White House Conference—Many communities throughout the United States are already geared to go into action, or are already in full swing, on President Truman's request — made in his Child Health Day Proclamation—for their continuing cooperation in carrying out the objectives of the Midcentury White House Conference on Children and Youth.

Here are a few random illustrations from hundreds that are being reported:

At Washington University, in St. Louis, Mo., a class in community organization is trying to find out what national organization facilities are available for State programs and how to use them.

In Florida a State-wide campaign has been launched to find children who need speech and hearing services. In the Sunshine State, also, a newspaper publisher has developed a special project to relate carrier work by newsboys to their homes and neighborhoods.

A Houston, Tex., school principal has set up a play-back machine in her office; and teachers and others listen to the conference recordings before school, at recess, and after school.

The State University of Iowa has announced a graduate seminar in interprofessional training and in understanding the problems of child development.

A number of governors, by proclamation, have set aside a period for emphasis on White House Conference follow-up. For example, Governor Bonner of Montana set aside the week of April 4-11, and Governor McMath of Arkansas designated the month of May.

At least 25 governors have held Little White House Conferences, such as the one Governor Kohler of Wisconsin called for April 19-21.

The Conference Technical Committee on Fact Finding met in Washington April 23 and 24, discussed its final report, and prepared a statement on what research is most urgently needed in the whole field of child growth and development.

A small conference staff, under the direction of Elma Phillipson, is continuing the organization of follow-up work for the conference. Among other services, the staff has held three of the six planned regional meetings with members of State committees to discuss plans for future activities. There will be a 2-day meeting in New York City May 28-29 to complete the formation of the new national committee for the conference.

Migratory farm labor.—State child-labor laws should be brought up to a level at least equal to that of the present Fair Labor Standards Act, and all such laws should be made fully applicable to agriculture. This is recommended by the President's Commission on Migatory Labor, which reported March 26, 1951, after devoting 9 months to studying conditions among migatory laborers.

Furthermore, the Commission recommends that the 1949 amendments to the Fair Labor Standards Act be retained and vigorously enforced. (These amendments make it illegal to employ children under 16 during school hours on commercial farms whose products go into interstate commerce.) And the Fair Labor Standards Act should be further amended, the commission says, to restrict the employment of children under 14 on farms outside of school hours.

Vigorous enforcement of the child-labor provisions of the Sugar Act of 1937 is also urged by the President's Commission. (Under this act, which provides for benefits to growers of sugar beets and sugarcane, producers of these are eligible for full benefit payments only if they do not employ children under 14 years or do not permit those between 14 and 16 to work longer than 8 hours a day.)

Urging that the President appoint a Federal Committee on Migratory Labor, the commission recommends that this new committee undertake to develop a plan that will provide an adequate program of education for migatory workers and their children. It recommends also that the Agricultural Extension Services expand their home-demonstration work to supply the families of farm workers, particularly migratory laborers, instruction in nutrition, homemaking, infant care, sanitation, and so forth; and that the Federal Government share in the cost of this educational program.

Among the other recommendations are that the Federal Government make matching grants to States for a housing program for migrants during the time when they are not "on the road"; for general assistance, including medical care for recipients of such assistance, regardless of legal residence; and for health programs and clinics for migatory workers.

Family relations.—Some of the many institutes, workshops, and conferences on family life that will be held this summer:

Kansas State College of Agriculture and Applied Science, Manhattan (June 7-20).

University of California, Berkeley (June 18-July 28).

Oregon State College, Corvallis (June 19-29).

Pacific University, Forest Grove, Oreg. (June 25-29).

University of New Hampshire, Durham (June 25-30).

University of Cincinnati (July 2-13).

Teachers College, Columbia University, New York City (July 2-14).

Teachers College, Columbia University, New York City (July 2-20).

Merrill-Palmer School, Detroit, Mich. (July 5-18).

Headquarters of the American Institute of Family Relations, Los Angeles (August 6-11).

"Family Style" annual conference of the National Council on Family Relations, at College Camp (on Lake Geneva), Wis. (August 26-31).

SUMMER COURSES

Western Reserve University. School of Applied Social Sciences, Cleveland 6, Ohio. Public Welfare Institute: Current problems in public welfare administration; and The responsibility of the social workers in public welfare agencies. (June 1-2, 1951.) Institute on Intercultural and Interracial Relations in Group Work. (June 13-16.)

Columbia University. New York School of Social Work. New York 28, N. Y. Three series of summer institutes in social work. Some of the courses in Series III: The normal development of the child; case work with the unmarried mother and adoption practices; and current policies and problems in child-welfare programs. Series I, June 18-29; Series II (for graduates of schools of social work), July 9-20; Series III, July 23-August 3.

University of Hawaii. School of Social Work. Honolulu. Treatment of juvenile delinquency (June 19-July 6); case work with children—advanced (July 9-27).

Nursery Training School of Boston, Boston 15, Mass. A special course, Implementing the Midcentury White House Conference, for experienced teachers, and workers in allied fields. Also regular courses in psychology of the preschool child; program planning for nursery school and kindergarten; home, school, and community; and play activities. Also practice teaching, and a try-out course for students who are considering entering the field of early childhood education. (June 25 to August 3.)

Louisiana State University. School of Social Welfare. Baton Rouge 3. Some of the short courses: Institute on children and youth—their government and their welfare (June 29-30). Workshop: Children and public welfare agencies (July 2-20). Some of the 9-week courses (June 8-August 11): Social services for children; children in foster care; visiting-teacher work.

Fisk University. Eighth annual Institute of Race Relations. Nashville, Tenn. For civic and youth leaders, teachers and students, social and religious workers, and so forth. (July 2-14).

Smith College. School for Social Work. Northampton, Mass. Graduate seminars for experienced social workers. The seminars are organized around three general aspects: Social case work, psychiatry, and supervision. (July 9-19.)

THE CHILD

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• CALENDAR

June 6-10—American Heart Association. Twenty-seventh annual meeting and twenty-fourth scientific sessions. Atlantic City, N. J.

From June 7 (about a month)—International Labor Conference. Thirty-fourth session. Geneva, Switzerland.

June 11–15—American Medical Association. Annual session. Atlantic City, N. J.

June 17–22—American Physical Therapy Association. Twenty-eighth annual conference. Glenwood Springs, Colo.

From June 18 (about 3 weeks)—United Nations Educational, Scientific, and Cultural Organization. Sixth session of the General Conference. Paris, France.

June 24–27—National Congress of Colored Parents and Teachers. Twenty-fifth annual convention. Dover, Del.

June 25–27—American National Red Cross. Annual convention. New York, N. Y.

June 26–29—American Home Economics Association. Forty-second annual meeting. Cleveland, Ohio.

June 29—American Hearing Society. Annual meeting. Chicago, Ill.

Regional conferences, American Public Welfare Association:

June 6-8—Mountain States, Salt Lake City, Utah.

June 24-26—Central States, Indianapolis, Ind.

To remind you.—

Each year, according to law, the Federal Security Agency sends each person on the official mailing list for *The Child* a postal card asking whether he wishes to continue to receive it.

When you receive such a card, be sure to answer it, if you want your name to be kept on the list.

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HE CHILD

JUNE-JULY
1951

STATE PUBLIC WELFARE AGENCIES DEVELOP THEIR SERVICES TO CHILDREN

UPERINTENDENT OF DOCUMENTS
JUL 18 1951

MILDRED M. ARNOLD

IN THE PAST 15 years, in every State and in many communities, public welfare agencies have developed their services for children rapidly. And last year Congress provided for even further expansion, bringing new emphasis to the programs and making it possible to meet some of the needs of children that previously had been unmet.

Three of the major bases for services to children by public welfare agencies are: (1) Partnership of the Federal, State, and local governments in promoting the welfare of children; (2) Partnership of public and voluntary agencies in offering services to children; (3) Responsibility of public welfare agencies for participating actively in community planning and organization.

We cannot think about the partnership of the Federal, State, and local governments without looking back momentarily into the history of our country. Our form of government dates back to days when the colonies inherited responsibilities that in the mother country were generally carried by the central government.

States provide safeguards

Under the Constitution of the United States, the authority to protect people in their personal liberty, their property, and their general welfare is left to the State governments. Hence the State, rather than the Federal Government, has the legal power to provide for safeguarding children and for intervening in their behalf. The methods of administering the safeguards vary from State to State. In some, the State administers the necessary services itself. In others, the State delegates the administration of these to local authorities and agencies.

How then does the Federal Government come into this picture? The Federal Government, under the Constitution, has the power to provide for the general welfare of the people, and the partnership in providing services to children is a threefold one—Federal, State, local.

We realize that State and local governments by themselves cannot carry the financial burden for providing these services. The long and terrible depression forced us to learn that. If such services are to be provided, the Federal Government must help to pay for them. And it is doing this through Federal grants-in-aid to the States.

The system of Federal grants-in-aid has its foes, some of whom charge that it is a device for further centralizing the Government. To me, however, such grants, instead of being a device for central control, are a device whereby the local and State governments can maintain their autonomy in administering the services in a way that would not be possible without the help of the Federal Government.

Although we realize that the Federal grants-in-aid programs still leave much to be done with regard to administration, coordination, and integration, authorities would agree, I believe, that such grants-in-aid are here to stay.

How does this system fit into our philosophy with regard to services to children? Does it advance or stymie what we believe should be done? Such grants are the best method we know of seeing that services for children are locally given, that they are planned and administered so that they are woven into family and community life, and that they reach a high standard.

The 81st Congress took another long and important step in further recognizing the responsibility of the Federal Government for the public welfare when it increased the authorization for grants-in-aid to the States for child-welfare services from 3½ million to 10 million dollars. The basis of allotment of these funds was changed to a flat grant to each State of $40,000 instead of $20,000, with the remainder allotted on the basis of the rural *child population* of the State to the rural *child population* of the United States, rather than on the basis of the rural *population*, as heretofore.

Congress also took steps toward solving a particular problem that had been presented to it, namely, the problem of the runaway child. It amended the Social Security Act so as to make possible the use of Federal child-welfare services funds for paying the cost of returning any runaway child less than 16 years of age to his own community in another State in cases in which such return is in the interest of the child and the cost thereof cannot otherwise be met.

The Children's Bureau has taken two important steps in putting into effect the amendments to the Social Security Act relating to child-welfare services. First, it has revised the regulations relating to child-welfare services, removing the ban on the use of these funds for the foster care of children; and secondly, it has issued a new policy manual concerning the use of Federal child-welfare-services funds. The policies in this manual allow for many new and important uses of the funds. These policies were developed after a series of regional meetings with State public-welfare

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Mildred M. Arnold is Director of the Division of Social Services, Children's Bureau. Previously she was Director of the Children's Division, Indiana Department of Public Welfare.

Miss Arnold began her career as a rural child-welfare worker in New York State.

This article has been condensed from a paper given by Miss Arnold at the seventy-eighth annual meeting of the National Conference of Social Work, at Atlantic City, N.J.

It is important to keep children in their own homes, and this principle is emphasized throughout the Children's Bureau manual on use of Federal funds for child-welfare services.

administrators, State child-welfare directors, and representatives of other public agencies and of voluntary agencies, climaxed by a meeting in Washington of representatives of national voluntary agencies concerned with the provision of services to children.

Federal child-welfare-services funds may now be used, under certain conditions, for the care of children in foster-family homes, day-care homes, group homes, and institutions. The further development of the basic State and local child-welfare programs through professional training of staff and expanded staff-development programs is stressed. The importance of keeping children in their own homes is recognized throughout the policy manual, and the use of Federal funds for certain services to make this possible, such as homemaker services, is permitted. In order that continuous study and evaluation of services may be made, Federal funds may now be used by the States for research in child welfare.

Thus we see some important trends developing in this partnership of the Federal, State, and local governments in meeting the needs of children. Of course, the future role of Federal grants-in-aid is still in the realm of political theory. But, as a country, we have faced up to the fact that the social problems of people must be met, and that they can be met only through the pooling of all our resources.

I turn now to the partnership of public and voluntary agencies in providing services to children. This is not a new partnership. Rather, it is one of our oldest partnerships. But recent developments have highlighted it and call for further analysis and development if this partnership is to result in the sound relationship the times and our present stage of social progress make essential.

In close partnership

All children's agencies, whether public or voluntary, have one thing in common. They are dealing with the problems of individual human beings. They have not become any different merely because the community has recognized and accepted a responsibility for meeting their needs, and through its lawmakers has decided to provide a service that will be supported from tax funds. They are the same when only a *part* of the community has recognized their need, and through its leaders has decided to provide a service through its own private resources. This common base, the problems of individual human beings, makes the partnership of public and voluntary agencies very real and very close—and inevitable if either group is to do its best work.

There was a time, now long past, when public welfare work was looked upon as mass care, in sharp contrast to the individualized services provided through voluntary effort. But that concept has no more place today in public welfare than it does in public education. Let's pursue this analogy even further. In the early days the large number of children to be educated and the volume of the task seemed to preclude anything more than the most elementary and rudimentary type of public-school education—and the cost of even this type of education seemed almost prohibitive. But fortunately for the future of our people and our country, our educational leaders never ceased to fight for an educational system that took into account the importance of individual differences and the need for an educational system that would recognize and meet these differences. Surely any field that has as its common element the intimate experiences of human beings in trouble must, like the field of education, abandon any thought of mass treatment and substitute instead a program that recognizes and treats the individual differences that lie at the root of the problems.

How can this partnership of public and voluntary agencies be effectively utilized for the common good? In my opinion we have spent too much time and energy in attempting to outline in specific terms the types of situations or problems that should be handled by public agencies and the types that should be handled by voluntary agencies. If we start from the base that both public and voluntary agencies deal with the problems of individual human beings, and then add to this the realization that these problems far outweigh the resources for their solution now available or likely to be available in the near future, it seems clear to me that we could spend our time more profitably in determining what skills and resources are needed to meet these problems, and in developing these skills and resources. The public and voluntary agencies together, either through an agreement as to the division of labor or by a careful plan supplementing each other's efforts, should strive to meet the *total* need of the *whole* community. Any other course prevents us from meeting our greatest challenge, the needs of the individuals in our communities.

We could move far toward our goal of meeting the total need of the whole community by making an inventory, and assaying, community by community, State by State, the most effective ways of utilizing all existing resources and the possibilities for the development of the additional ones that we need. And I like to think that this in effect is what the new proviso in the amendments to the Social Security Act can mean. This proviso states with regard to child-welfare services that "in developing such services for children the facilities and experience of voluntary agencies shall be utilized in accordance with child-care programs and arrangements in the States and local communities as may be authorized by the State."

Throughout the discussion at the regional conferences called by the Children's Bureau last fall the important role of voluntary agencies in the total program of social services to children was recognized. All the conferences stressed that there are many ways by which the experience and resources of voluntary agencies may be utilized in child-welfare programs, including: (1) Participation with representatives of public agencies and with citizens in broad community planning, such as on State and local planning committees for children and youth; (2) joint effort by representatives of voluntary and public agencies in working on particular problems in individual communities through councils of social agencies and other interagency committees; (3) participation on advisory committees of State and local public-welfare agencies; (4) consultation to State and local public-welfare agencies regarding matters affecting the welfare of children; (5) participation in joint staff meetings of public and voluntary agencies to discuss common problems; and (6) participation on official policy boards of public agencies.

The policies stated in our child-welfare-services manual attempt to build on and strengthen this cooperative relationship between public and voluntary agencies and to permit utilization of the resources of voluntary agencies to better meet the needs of the individual children who are the responsibility of the public agency. Federal child-welfare-services funds may now be used to finance certain services rendered to the public agencies by voluntary agencies in accordance with cooperative arrangements subject to the provisions set forth in the manual.

Both public and voluntary social agencies deal with problems of individual human beings.

We have an opportunity now, as never before, for the public and voluntary agencies to join together, through combined efforts and through a pooling of all resources, to refine practice and to carry services to children to greater heights of achievement. We are all familiar with the vast areas of unmet need. We all know the dangers of turning unskilled and inexperienced workers loose in this area. Let us then go about the task of providing services in areas wholly without them, of setting up the various kinds of services needed to meet individual needs, and of preparing the workers with the necessary skills.

My third point is the importance, in the light of present-day developments, of public-welfare agencies' participating actively in community planning and organization. All the Bureau's regional child-welfare conferences stressed that community planning is essential for the establishment of new services, the extension and strengthening of existing services, and the full use of all community resources and interests, under both public and voluntary auspices, in programs of social services for children and youth.

Community planning and organization is, of course, not new to the field of social work. It has been with us for a long time. We can look to the Social Security Act—not the 1950 amendments, but the act itself as originally passed in 1935—and find recognition of its importance in public-welfare services. In the child-welfare services section of the act, part of the Federal funds made available are to be used "for developing State services for the encouragement and assistance of adequate methods of community child-welfare organization in areas predominantly rural and other areas of special need." In the Annals of the American Academy of Political and Social Science (Nov. 1940), Arthur Dunham pointed out that this is probably the first instance of the use of the phrase "community child-welfare organization" in American law and that the appearance of this phrase in the most far-reaching public-welfare statute in the history of the United States indicates an important trend in this country.

Social action, or what used to be known as social reform, has always been an integral part of the social-work profession. We have never been content to separate our casework services to individuals from some responsibility for preventing or controlling social factors that cause or intensify the problems with which we work. But today social work is making a more systematic and conscious effort to influence the basic social conditions out of which arise the problems of social maladjustment to which we, as social workers, devote ourselves.

After the Midcentury Conference

We are faced with the task of defining the nature and scope of the responsibility that our profession has in community planning and organization. And now is an opportune time for doing this. The 1950 White House Conference on Children and Youth represents the active participation, in every State and in over a thousand local communities, of the various professions and citizens' groups working together for the welfare of children. These State and local communities are actively carrying on the follow-up work of the conference. Social agencies, public and voluntary, must find their proper niche in this great effort—and they must be prepared to make their own unique contribution to it.

We have learned much from our experience with the White House Conference that we can build on. We have learned how to secure wider participation and more effective action from various groups. We have learned to understand and appreciate more fully the contributions from various fields and how to integrate them into a meaningful whole. We have come to appreciate anew the need for flexibility in planning. The story of the State committees in action shows that no two State committees were exactly alike, yet all succeeded in mobilizing community and State efforts for children. We know that what we are trying to do can be done. Citizen groups must band together, community by community, State by State, to analyze their own changing cultural patterns, to collect and study the facts they themselves have assembled, to face their own unmet needs, to coordinate their existing programs and to organize opportunities and services for their own children and young people.

The new child-welfare-services manual sets forth a policy directed specifically to community planning and organization. This policy defines community planning and organization for children as including the activities — (1) that identify needs of children and youth and determine causes of their problems within the community; (2) that determine appropriate and effective methods of community action to eliminate the hazards to the welfare of children and youth; (3) that determine and take steps to establish or strengthen programs, services, resources, and facilities to meet needs; and (4) that coordinate programs of the various community agencies into a network of services in behalf of children and youth. Federal funds may be used, under certain conditions, by the public-welfare agencies in this important area.

Much remains to be done

A firm foundation has been laid for services to children in this country through the partnership of the Federal, State, and local governments. On this foundation some kind of organizational structure has been built in every State. The conviction that child-welfare work is a professional service has finally taken root. A merit system for selection and appointment of staff is in operation in every State. All States save three provide for the professional training of child-welfare workers through the use of Federal funds. (The amount of funds budgeted for this purpose alone this year amounted to approximately $765,000, which will provide for the training of an estimated 550 workers.) Staff-development programs, for the continual improvement and advancement of personnel, are now in operation in all States, of course with variations. These accomplishments make possible the further evaluation of unmet needs and the assaying of ways and means for meeting them more adequately.

We still have a great need for wider coverage of services. Although, in June 1950, 42 percent of the counties were being served by full-time public child-welfare workers, vast areas were still without this service.

We need constantly to refine and improve our skills in helping people reach their maximum attainment of a full and self-sustaining life. We need more and greater perfection of the tools with which we work—tools such as homemaker services; household aides; specialized group homes; foster-family homes; and some of the specialized services such as psychiatric, psychologic, and remedial services. The new policies of the Children's Bureau are geared not only to improving the skills of workers but to increasing and perfecting their tools.

We need further adjustment of government structure and machin-

(Continued on page 185)

CHICAGO'S PUBLIC HOUSING PROGRAM HELPS TO SAVE BABIES' LIVES

Better living conditions plus health services reduce infant mortality rate

J. S. FUERST

ROSALYN KAPLAN

EACH YEAR many thousands of babies who under present conditions die in infancy would live to see their first birthday cake if they had the good fortune of the babies born to parents in Chicago's public housing projects.

In 1947-48, when we studied infant mortality in the projects, we found that babies living in these housing communities had a better chance for survival than did those in areas surrounding the projects. And that they had a better chance than did babies in Chicago as a whole, and for that matter, those in the 106 largest cities in the United States. (See chart.)

This comparison might be used to show that when families move into good housing they can be sure that their babies will have a much better chance of surviving than if those babies started their lives in the darkness and dampness of a slum home. In short, out of these findings we might be inclined to make a "1+1=2" demonstration in behalf of decent housing.

Or, as has been done before, we might maintain that the health services that are made available by public housing projects are responsible for the saving of the babies' lives.

But it is not good housing alone nor health services alone that produce low infant mortality rates among families in housing projects. It is a housing-and-health combination that makes the improvement possible and that offers such unlimited possibilities for future improvement of the health of the country's babies.

Of course, any study of infant mortality and housing should start out with the more obvious relationships between health and housing. Aside from the deaths due to premature birth, birth injury, and congenital malformations, which kill mostly in the first month of life, most of the deaths of babies in their first year are caused by pneumonia and influenza, "diarrhea, enteritis, etc." (the terms used by the National Office of Vital Statistics) and certain communicable diseases. [1] The fact that deaths from these causes are associated with crowded housing has long been known. [2]

A sample of slum conditions

Despite all the care that the mother of a slum family may give her baby, her efforts are easily frustrated by unhygienic living conditions, such as those under which 3,600 families live, in an area adjoining one of the Chicago Housing Authority's projects. [3] Rats, mice, roaches and other kinds of vermin infest more than half the buildings; stoves and makeshift arrangements are the only means of heating for nearly 85 percent; almost seven-eighths of the individual flats are dilapidated or are in dilapidated structures; a little less than half the houses lack bathing facilities; toilets in good condition amount to less than one per dwelling for every other building. A dreary summary, indeed, of the harsh physical environment that greets the newly born child.

Physical environment improves

When a family that has been living in such an area moves to one of the housing projects it finds adequate living space, better light and ventilation, daily garbage disposal, and complete sanitary facilities. Central heating replaces the winter stove, and screens keep out the summer flies. And the members of the household are not crowded together. The Chicago Authority, like other such authorities, permits only one person per room, or slightly more in large-family apartments. A slum, on the other hand, has no occupancy standards.

Our plan was to compare the infant mortality in the housing projects with that in slum areas in which the setting was reasonably comparable. We would have liked to compare an exactly similar group of families in the slums and in the projects. But in socio-economic experiments such controls are not easily found. We would also have liked to compare well-housed families with families in areas that were entirely slums. But this was impossible, for the city's vital statistics are collected only for large "community areas" which may include

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He received his master's degree from the University of Chicago's School of Social Service Administration.

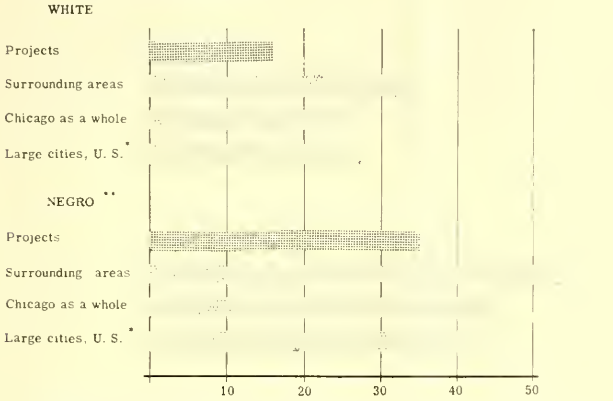
Mrs. Rosalyn Kaplan is a research analyst for the Chicago Housing Authority. She has done graduate work at the University of Chicago and has just completed a study of the salaries of employees of local housing authorities for the National Association of Housing Officials.

both slums and other neighborhoods. However, if the areas we used for comparison had been *entirely slums*, the results would undoubtedly have been even more favorable to the projects.

Four of the projects are surrounded by neighborhoods that are largely slum areas (the other projects are surrounded by vacant spaces); and these were selected as control groups.

Residents of the surrounding areas, on the whole, were comparable to the project residents. The ratio of Negroes to white people was the same. The income of the families in the surrounding areas was slightly higher than that of the families in the projects, partly because the latter had been rehoused chiefly on the basis of need. The proportion of families that either lacked one of the parents, or were receiving some form of public assistance, or included one or more unemployed workers, was greater in the project families. All this would not lead us to expect better infant mortality rates in the housing projects.

INFANT MORTALITY RATES IN CHICAGO HOUSING AUTHORITY PROJECTS, 1947-48
(deaths under 1 year per 1,000 live births)



* 106 cities of 100,000 population or more (1940 census).
** Mortality for Negro groups includes also a few deaths of nonwhite infants other than Negroes

In the 2-year period 1947–48, 437 white 1,201 Negro babies were born in Chicago's public housing projects; 7 white and 42 Negro babies died in their first year.

Through the cooperation of the city health department we obtained information, for the projects and for the surrounding areas, on the number of infants born during 1947 and 1948 and on the number of those under 1 year of age that died during that period.

We compared the infant mortality rate (number of infant deaths per 1,000 live births) in the projects with that in the surrounding areas, to see how well the families in each had been able to keep their babies alive for a year at least.

Among the white families in the housing projects the infant mortality rate was 16.0; in the surrounding areas it was more than twice as high, 33.6.

For Negro families the contrast between the rates was also surprising. The rate for Negro babies in the projects was 35.0; for those in the surrounding areas, 53.9. That is, Negro babies in these areas stand more than half again as great a risk of dying before they are a year old as do those in the projects.

Of course infant mortality rates throughout the Nation have been improving for some years. In Chicago, for example, the rate dropped in 20 years from 60.0 to 28.5 (1948). However, in spite of this improvement, the mortality among Negro babies in the slums has just about reached the figure that the mortality for white babies reached at the turn of the century.

The fact that we are reporting rates for white and Negro babies separately should not suggest that there is any inherent difference in the people of the two groups that would lead to higher or lower infant mortality. But even though both white and Negro families move out of slums and into better quarters, this does not immediately give the Negro infant an equal chance to survive. General economic and social disadvantages contribute unfavorably to health as well as other problems.

The differences that we found in infant mortality rates between the housing communities and the other areas have been partly forecast by the results of studies in other cities.

Early studies showed high infant mortality rates in slums and lower rates in good residential areas. Such studies were carried on in many urban centers, such as San Francisco, New York, and Cincinnati. In almost all the studies, however, there are so many variables that it is almost impossible to establish a one-to-one causal relationship between infant mortality and housing. More recent studies, on *public* housing projects, including the present one, have attempted to deal with this problem by controlling one important variable, namely, income, since public housing projects are built only for families of low income.

What similar studies show

Extensive studies have been made in Newark, N. J., and in Pittsburgh, Pa. [4] [5]. In Newark, in 1943, a study of infant mortality showed that the rate for a group of public housing projects (16.3) was less than half the rate in comparable wards of the city (42.4). The rate among the white babies in the projects was 14.9, less than half the rate for the comparable wards (30.8). Among the Negro babies the rate in the projects was 17.9, and in the comparable wards it was 62.5. In Pittsburgh, in the same year, the infant mortality rates among families in public housing projects were compared with the rates among families in various economic brackets. And for both white and Negro families living in the projects the rate was lower than that for any comparable economic group.

Buildings not the whole story

Almost all the earlier studies and many of the more recent ones have stressed the effects of new brick and fresh mortar, apparently overlooking the importance of health services and integrated community facilities.

In public housing much is added besides the buildings. And, because of the improved environment for living, in terms of health and recreational opportunities, improved infant mortality rates in public housing projects measure more than the effect of physical housing itself. The lower mortality rates found are a result of the additional factor achieved under a public housing program that seeks to rebuild the community as well as the houses.

In the planning and management of the Chicago housing projects, the services of health and welfare agencies are enlisted to help develop a community that will meet the needs of everyday living, including the needs of mothers and infants.

Health services often inaccessible

This is not to say that the slum families who are still not rehoused do not receive some of these services. But many of these families have difficulty in making use of them. The slum mother whose child needs medical attention may live too far from the clinic. And, constantly plagued by slum-bred problems that gnaw away at the spirit as well as the pocketbook, she may become discouraged. Dispirited by the cumulative conditions in the home to which she must return, she may make the trip to the clinic once, but not again. As a result, her sick baby may not get well.

Undoubtedly the saving of a baby's life depends largely on the medical care he receives. And there can be no challenge to the evidence that, as a rule, low-income families, and particularly those living in slums, receive far less medical care than families in better economic circumstances. One exhaustive study [6] found that, among families whose income was above the median level, 80 percent of their children's illnesses received medical attention; but among families on relief, only 65 percent.

We know that it is "expensive to be poor," but it is especially so for Negroes. A 1948 study of segregated neighborhoods in New York City shows that the Negro family living in a Negro residential area pays more money for rent, obtains inferior housing, and has less budget money available for food and medical care than a similar family in a nonsegregated area. [7]

The same study revealed that Negro babies born in a nonsegregated neighborhood had a 60 percent greater chance of surviving their first year of life than did those born in a segregated area, although there were no significant differences in socio-economic status between the segregated and the nonsegregated areas. Even miracle drugs cannot cope with social disorganization.

All over the United States infant mortality has been shrinking, but slum "islands" of high infant mortality remain in many cities. In these neighborhoods it is difficult to see progress in improving public health, even when health agencies put forth their greatest efforts.

The Chicago Public Housing Projects facilitate the efforts of health agencies. For example, four of the larger projects provide space for maternal and child-health centers in the project buildings. Two of these centers are operated by the city health department and the others by the Infant Welfare Society, a private organization. The services are available not only to project residents, but also to people living elsewhere.

In addition to routine and emergency treatment of mothers and infants, prenatal care is provided, including home nursing visits. No one knows how many premature births are avoided through these services, but there can be little doubt that the services have a favorable effect on the infant mortality rate.

In slum neighborhoods such as these it is difficult to see progress in the improvement of public health, even when public and private health agencies put forth their greatest efforts.

During 1948 these centers gave children nearly 6,000 inoculations against diphtheria, tetanus, whooping cough, and smallpox; 60 percent of these shots were given to children living in the projects. The Infant Welfare Clinics offer monthly examinations to all infants and preschool children. Each child receives a physical check-up by the physician in charge, not only to check on weight and general health but also to detect latent symptoms of disease or disability so that the earliest possible treatment may be given. This examination also includes specific advice from nurses concerning nutrition and diet.

Project families are interested in health

In housing projects other factors besides nearness of maternal and child-health centers operate to help the families living there to make use of available health services. In contrast to the disorganized and hostile atmosphere of the slum neighborhood, the project itself presents a pattern of community life. In such an atmosphere, a mother is more likely to become enlightened about health measures. She learns more about sanitation, personal hygiene, and immunization, and this leads her to seek medical care for her family, whether or not facilities are close to where she lives.

A sample of the initiative in health matters that is shown by project residents is the establishment of a free dental clinic for children through the efforts of people living in one of the projects, Altgeld Gardens. Upon a promise by the Chicago Board of Health that it would provide dentists if space and equipment for the clinic were furnished, the housing authority provided the space, and the residents raised more than $1,000 toward buying equipment. The University of Chicago contributed toward buying the equipment; and plumbers, electricians, and engineers on the housing authority maintenance staff installed it without charge.

The city board of health has provided dentists, and so has a professional dentists' group whose members serve the clinic without charge. Women residents of Altgeld Gardens serve as volunteer attendants, after being trained for this work by the clinic dentists. The clinic has now been in operation for more than 2 years.

In the United States as a whole, local housing authorities have made only limited progress in clearing slums and rehousing the slum-dwelling families. It is now time to begin to think in long-range terms of a diversified program in relation to other municipal agencies when the core of a city is rebuilt and new communities grow up in outlying sections.

This and previous studies leave no doubt that decent housing and public-health programs go hand in hand. But the infant mortality figures for the Nation as a whole still show, in needless deaths, the effect of unmet housing and health needs. The possibilities of saving life that our study and others suggest should encourage the agencies that share in the responsibility for child health and should stimulate the public to demand more of the same.

Facilities for safe, healthful, and happy play go hand in hand with improved housing.

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Reprints in about 6 weeks

FOR BETTER CARE OF PREMATURE BABIES

Pediatricians and nurses learn together to improve their work for the premature

NOW that programs for the care of premature babies are developing rapidly throughout the country, it is realized more and more that although special physical facilities and equipment are valuable tools used in caring for these babies, even more important is the quality of medical and nursing care the babies receive. This is especially true of the smaller prematures and of other babies whose chance for life is poor. And experience has shown that both the pediatricians and the nurses who care for premature babies need special preparation for this work.

For several years selected nurses in different parts of the United States have been attending special courses or institutes offered by centers for the care of premature babies. State and local health departments, assisted greatly by Federal maternal and child-health funds, make arrangements—including payment of stipends—to enable both hospital and public-health nurses to improve their skill at these centers. Later the nurse returns to her own hospital to apply the knowledge she has gained at the teaching center.

These teaching programs have considerably improved the skill of the nurses who have attended them, and undoubtedly have thus helped to save many premature babies' lives through better nursing care. The saving of a premature baby's life, however, is not an individual job, but a cooperative one. If success is to be achieved in this difficult task, help from many fields must be had. And unless the nurse who returns to her own hospital receives support in putting what she has learned into practice—support from the pediatrician, from the hospital administrator, and from others important in the program—the premature babies may not get the full benefit of the nurse's special skill. And the work of the teaching center may be to some extent wasted.

When this baby is ready to leave the hospital, his parents should know that he will need medical, nursing, and other special care at home. These needs are becoming more widely recognized as pediatricians and nurses together study the care of these babies.

Sometimes a nurse finds actual opposition to using what she has learned at the teaching center. Such opposition may be encountered, not only in relation to improving the services within the nursery itself, but also with regard to providing other services that are part of the complete program of care for the premature baby. For example, some pediatricians and hospital administrators may not feel that it is necessary to teach the parents of a premature how to care for him at home. And they may not realize that it should be explained to the parents that the baby needs special services — medical, nursing, and other—after he is taken home from the hospital; and that the parents usually need help in getting these services for the baby.

With the rapid expansion in programs for the care of premature babies, the need for special preparation in this field for both physicians and nurses has become clearer and clearer. And so, about 2 years ago, the health departments of New York State and New York City joined with the Federal Children's Bureau in requesting the New York Hospital-Cornell Medical Center to start a program for teaching teams of pediatricians and nurses. Planning was done by these three agencies in cooperation with the hospital, and a series of institutes was begun in the fall of 1949, financed by a special grant of maternal and child-health funds by the Children's Bu-

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This discussion of special study of the care of premature babies by physician-nurse teams was written by three such teams: Helen M. Wallace, M.D., and Margaret A. Losty, R.N.; Edward R. Schlesinger, M. D., and Madeleine Y. Phaneuf, R.N.; Margaret Dann, M.D., and Ethel Tschida, R.N.

Dr. Wallace and Miss Losty are on the staff of the New York City Department of Health; Dr. Schlesinger and Miss Phaneuf, of the New York State Department of Health; Dr. Dann and Miss Tschida, of the New York Hospital-Cornell Medical Center.

reau to the New York State Department of Health. These funds provide for stipends for both pediatricians and nurses.

The program for each year consists of four series of institutes. Each institute offers 2 weeks of full-time instruction—9 a.m. to 5 p.m., 5 days a week—for the pediatrician-nurse teams, and 2 additional weeks of active experience for the nurses in caring for premature babies. A few nurses have been permitted to stay on for further work experience.

The program is conducted by two pediatricians and a nursing supervisor. The nursing supervisor devotes the major part of her time to the institutes; the two pediatricians assist in selecting the candidates and in planning and carrying out the program.

A wide range of subjects is covered by the institutes. Some of them are: Broad community aspects of the problem of premature birth: obstetric measures for prevention of premature birth; and planning of a hospital unit for premature babies. Other subjects discussed include: Immediate care of the premature infant in the delivery room, and resuscitation procedures; physiological handicaps of the baby born prematurely; his metabolism; his feeding; environmental factors in the care of premature infants; control of infection; and retrolentral fibroplasia. Attention is paid to the emotional and social needs of the babies and their parents and also to the costs of care.

Instruction of parents is given special emphasis.

The institutes include a visit to the home of a premature baby, with a staff member of the Visiting Nurse Service of New York; and afterward the pediatricians and nurses discuss the home follow-up program. They visit the Premature Transport Service of the New York City Department of Health and observe the procedures in a special follow-up clinic for premature babies.

The physicians who give lectures and demonstrations include obstetricians; pediatricians in public health; and pediatricians who have research or clinical experience in subjects bearing on the care of prematurely born infants, such as pathology, physiology, hematology, ophthalmology, and the emotional and social factors in the care of such infants. Nurses, nutritionists, and social workers also give lectures and demonstrations.

Demonstrations emphasize the principles for successful care of premature babies and the judgments necessary for carrying out these principles. The principles are: To maintain the baby's body temperature; to maintain his respiration; to protect him from infection; to maintain his nutrition; to conserve his energy.

Throughout the institutes ample opportunity is given for free group discussion, during which controversial points can be examined from both medical and nursing viewpoints.

Teams selected to attend the institutes consist of pediatricians and nurses who supervise, or plan to supervise, a community or regional program of care for premature infants, or who are responsible for the care of such infants in a special premature-infant center. Final selection of the pediatric and nursing members of the teams is made by the staff of the New York Hospital-Cornell Medical Center on the basis of recommendations made by the New York City and New York State health departments and by the maternal and child-health directors of other States where the candidates are located.

By and large the pediatricians and nurses accepted from New York City and up-State New York have been in charge of centers for the care of premature babies. Those from other States usually have been pediatric or nursing administrators or consultants in a community program for such babies. The intermingling of these various types of personnel has brought together different viewpoints. And the interests of the pediatricians and nurses broaden considerably as the public-health workers hear more about the clinical problems met in caring for premature infants and as the clinicians learn more about the community problems related to such care.

As a rule the pediatrician in charge of a premature nursery of a specific hospital or of a State program and the supervising nurse are trained together. In two instances a third member was added to this team, a public-health nurse working in the area where the nursery was located. This addition to the team is a highly desirable one, as the public-health nurse can do much to help the premature baby's parents see that the baby gets the care he needs.

Whenever possible, plans are made for the personnel of a projected center for the care of prema-

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Although special physical equipment and facilities are valuable tools in the care of premature babies, even more important is the quality of medical and nursing care they receive.

CHILDREN AND YOUTH ARE CITIZENS

STANLEY E. DIMOND

"EVERY person born or naturalized in the United States is a citizen of the United States." This is what textbooks on civics usually tell us. But many of us fail to realize that citizenship really does begin at birth or naturalization. We are likely to forget that children and youth, born or naturalized here, *are* citizens — that citizenship is not postponed until a person reaches voting age.

Young people take an important part in the work of the National Conference on Citizenship, at whose meetings, sponsored by the Department of Justice and the National Education Association, representatives of organizations concerned with education for citizenship gather annually to exchange experience.

The most recent of these meetings, the Sixth National Conference on Citizenship, was held in Washington May 16–20, 1951. Young people had joined in planning the conference. They participated in the 22 discussion groups that are its backbone. Youth was highlighted, too, in the general sessions.

Some people might think that young people would have a difficult time on a program that featured addresses by the President of the United States, two United States Senators, and the Attorney General, as well as officials of the National Education Association, newspaper men, and radio commentators. The young people were impressed by the sincerity, seriousness, and forthrightness of these speakers, but they were not eclipsed.

With Dorothy Gordon, director of the New York Times Youth Forum, as moderator, six young people broadcast their ideas on "A Citizen's Responsibility in a Democracy" over a national radio network.

And who are these young people? Claudette James, 14 years of age, from Forsythe, Ga., nominated by the Future Homemakers of America, was a high-school representative. A 16-year-old girl, Joy Alexander, from Burns Flat, Okla., was nominated by the 4-H Clubs as a representative of high-school youth. Gerald Richards, a 17-year-old YMCA nominee from Elmira, N. Y., also represented high-school youth. Working young people were represented by Mary L. Coleman of Baltimore, Md., 22 years old, nominated by a labor union. Arthur Robinson of Washington, D. C., and Richard Wilson of Philadelphia, Pa., were the college representatives. Robinson, an 18-year-old, was nominated by the American Legion. Wilson, 23, was nominated by the Boy Scouts of America.

As guest of the young people, W. Averell Harriman, Special Assistant to the President, answered their questions and also questioned them. Mr. Harriman epitomized the feelings of all present when he told his young panel colleagues, "I have come to learn."

What is youth saying? At the Sixth National Conference on Citizenship, they were saying: "We must learn to live with all types of people." . . . "Society does not owe us a living; society owes us an opportunity." . . . "The job ahead of this generation is to build a free world." . . . "Youth should listen to adults, but should formulate their own opinions." . . . "We are ready to serve our country, in peace and in war."

The Sixth National Conference on Citizenship has demonstrated that young people are mighty active citizens when adults give them a reasonable chance.

Reprints in about 6 weeks

Stanley E. Dimond is Professor of Education at the University of Michigan. Dr. Dimond was director of the Detroit 5-Year Citizenship Education Study, which ended June 1950.

He is a member of the Citizenship Committee of the National Education Association of the United States.

CHILD-WELFARE SERVICES

(Continued from page 177)

ery to meet the needs of the people. We do not yet have effective long-time planning either at the Federal or the State level for accomplishing this—planning that includes comprehension of emerging trends, a clear formulation of objectives in the light of these trends, and a conception of the most effective and economical means for attaining these objectives. But such planning cannot be done once and for all. Just as our social structure is in a continuing process of change, so must our planning to meet the needs of people be an always-changing process. Life itself is fluid and shifting. So must planning be dynamic and flexible. New standards in public values will emerge, and plans must be modified in accordance with the changing times.

Yet, even in the face of all our gaps and lacks, I am optimistic about the future developments in services to children, for I believe that the future is challenging. We have vast resources now at hand. But the most effective use of these resources requires a clearer recognition and acceptance of public responsibility for the promotion of the general welfare of all the people, as set forth in our Constitution. Planning must be done with hope, vision, and creativeness. Through such planning we can help provide a better life for all our people.

To remind you.—

Each year, according to law, the Federal Security Agency sends each person on the official mailing list for *The Child* a postal card asking whether he wishes to continue to receive it.

When you receive such a card, be sure to answer it, if you want your name to be kept on the list.

PREMATURES

(Continued from page 183)

ture babies to attend an institute well in advance of the opening of the center. This plan enables the pediatrician and the nurse to have enough time after the institute is over to plan jointly concerning the most desirable procedures and policies for their center.

Usually one of the first steps taken by a team that has attended an institute has been to establish a manual of joint policies and procedures for the operation of their nursery or center. The team decides upon the policies and procedures together, and this partnership has produced better results for the premature babies.

In New York City, shortly after each pediatrician-nurse team completed attendance at an institute, the pediatric and nursing members of the Maternity and Newborn Division of the New York City Department of Health held a conference with them in order to assist the team in setting up their premature center as quickly as possible.

Although the joint instruction program has been in operation only 2 years it has undoubtedly contributed to raising the level of the care given to many premature infants.

During the first 2 years of the program 40 pediatricians and 40 nurses attended the institutes; of these, 21 pediatricians and 23 nurses were from New York State and New York City. They represented 13 centers for the care of premature babies.

The demand for places at the institutes has far exceeded available facilities. Progressive expansion of the training program is planned, to make possible an increase of enrollment to 30 teams of pediatricians and nurses in 1951–1952. Twenty places will be reserved for personnel from all parts of the country exclusive of New York State. Inquiries from candidates should be sent to the maternal and child-health directors of State health departments.

Reprints in about 6 weeks

• FOR YOUR BOOKSHELF

FOR FATHERS WHO GO TO WAR. Here and Now Series. Pamphlet No. 1. By Loyd W. Rowland, Ph.D., Director, Louisiana Society for Mental Health, 816 Hibernia Building, New Orleans, La. 1951. 10 pp. Four copies for $1.

This little leaflet deserves wide and prompt distribution. We have ample evidence that homecoming after the last war might have been a more joyful occasion for many fathers if they had known more about what babies and children are like, and had been prepared for the fact that their young children would not remember them very well. The many practical suggestions in these pages should prove most helpful to both wives and husbands in dealing with some of the problems caused by separation.

Marion L. Faegre

YOU AND YOUR HEALTH. By J. Roswell Gallagher, M. D. Science Research Associates, 228 South Wabash Avenue, Chicago 4, Ill. 1950. 48 pp. 60 cents.

Science Research Associates editors chose well in selecting Dr. Gallagher to write this booklet on health, as part of the series planned to help young people solve the problems of everyday living. Not only is he an authority on health, but also he has learned to understand young people through his work as director of health services, first in a preparatory school and now in a university.

The topics discussed are those that adolescent and college-age youths want to know about: Pattern of growth; physical fitness; food; factors in accidents; prevention and control of diseases that occur among young people; and other health matters that often worry them, such as acne, headache, alchohol, tobacco, menstruation.

The author says that youths need more than facts about health. "What you *learn* about health, however, is only one side of the story," he says, "Your *attitude* toward health is even more important. You need facts to help you live more effectively, but you also must know how to use them." This booklet contains the facts, and one has the feeling that readers' attitudes and behavior will be altered by them.

There is no stuffy advice. The writing is lively, entertaining, and full of meaning for youthful readers. There are larger books that contain more information about health, but it is doubtful whether there is one more accurately aimed at health questions of the younger generation or more appealing to the readers.

Eighteen humorous drawings by Kathleen Shepherd help.

As accompaniments to You and Your Health, the publisher also issues an instructor's guide and a life-adjustment poster for use by the teacher or group leader.

Thomas E. Shaffer, M.D.

A MANUAL OF CEREBRAL PALSY EQUIPMENT. The National Society for Crippled Children and Adults, Inc., 11 South La Salle Street, Chicago 3, Ill. 1950. 127 pp. $5.

Although the equipment decribed in this manual is planned for use in the treatment and education of children with cerebral palsy, some of it can be used also to help children with other conditions who need speech therapy, occupational therapy, physical therapy, or special education.

The equipment is designed to be used only under medical supervision.

A good photograph and a working drawing are given for each piece of equipment, as well as a list of the materials needed for making it. For each item also, an explanation is given of the way it can be used, its limitations, and precautions that should be taken in using it. This explanatory material is of inestimable value.

This book is much more than a mere list of equipment, or even a manual for its construction. It states the principles upon which are based the child's activities in connection with the equipment.

The National Society hopes that supplements to this manual can be published from time to time as new equipment is designed.

This is a valuable source book for use by anyone responsible for the care and treatment of crippled children.

Clara M. Arrington, P.T.

"What does it matter, when you come to think of it, whether a child is yours by blood or not? All the little ones of our time are collectively the children of us adults of the time and entitled to our general care."

—Thomas Hardy

• IN THE NEWS

Community Health— Many communities today are unable to take full advantage of the health protections which modern science has evolved, because they do not have an adequate public health department. This fact is so widely recognized by professional and civic leaders that the attainment of better local health services has become a major goal of most organizations that are interested in health matters.

To assist these local leaders, the Public Health Service is cooperating with the Health Publications Institute, a private nonprofit foundation, in compiling informational materials which could not be economically produced by individual communities but which can be readily adapted to local educational campaigns.

These materials include: A 12 minute technicolor film, "So Much for So Little," and a discussion guide suggesting ways for using the film in organizing local action programs; a series of 13 transcribed radio programs on the work of a local health officer; a reprint, with color photography, of the Saturday Evening Post article, "Public Health Doctor"; a short pamphlet describing what a local health department does, how it is staffed, and what it costs; exhibits for store windows or meetings; and an easy-to-use gage which enables civic groups to measure the effectiveness of their community's existing health services.

Further information about this project can be obtained from State health department; or from the Public Health Service, Washington 25, D. C.; or from the Health Publications Institute, Raleigh, N. C.

Epilepsy— A training course in the diagnosis and treatment of epilepsy, and in electroencephalography, is to be conducted at the Seizure Division of the Children's Medical Center in Boston, under a special grant from the Children's Bureau, acting through the Massachusetts Department of Public Health. A limited number of physicians and prospective electroencephalographic technicians will be accepted. The first course begins July 1, 1951. Details may be secured from State health departments, or from Dr. William G. Lennox, 300 Longwood Avenue, Boston, Mass., who will have general direction and to whom applications should be made.

This Is Civil Defense is the third of a series of booklets for the public, published by the Federal Civil Defense Administration. The previous two were Survival Under Atomic Attack and What You Should Know About Biological Warfare. All three bulletins may be purchased from the Superintendent of Documents, Washington 25, D. C., at 10 cents a copy. 25 percent discount on orders of 100 or more.

What You Should Know About Biological Warfare will be the subject of an official motion picture, to be released early this summer.

The FCDA has issued also an "alert card," carrying air raid instructions for families. The price of these cards is $3.75 per 100, also from the Superintendent of Documents.

Among the other publications of the FCDA, purchasable from the Superintendent of Documents, are:

Damage From Atomic Explosion and Design of Protective Structures. 15 cents.

Civil Defense Against Atomic Warfare (a Selected Reading List). 10 cents.

Medical Aspects of Atomic Weapons. 10 cents.

Fire Effects of Bombing Attacks. 15 cents.

United States Civil Defense. 25 cents.

Health Services and Special Weapons Defense. 60 cents.

National Security Factors in Industrial Locations. 15 cents.

Advisory committee on young workers — Ways to prevent a further decline in high-school attendance in the face of growing demands for workers were discussed April 13, at Washington, by a committee of 28 recently appointed by the Secretary of Labor to advise the Department's Bureau of Labor Standards on the protection of young workers. The committee members represent the interests of education, State governments, agriculture, industry, labor, parents, and civic groups.

The committee also explored ways of bringing about better on-the-job conditions for young people employed as vacation and part-time workers. Special attention was given to safeguards for children working in agriculture.

A dozen States had reported a marked increase in the issuance of employment certificates to boys and girls under 18. In these States 69 percent more 16- and 17-year olds left school for work during the 4 months ended January 1951 than in the same period of the preceding year.

In the light of these figures, which show a rising tide of jobs for young workers, the committee resolved to find ways to increase the effectiveness of legislative standards governing employment of young people as set by State laws and the Federal Fair Labor Standards Act.

Katharine F. Lenroot, Chief of the Children's Bureau, serves as a Government adviser to the committee.

Fellowship announcements— Fellowships in child psychiatry are still available for September 1951 in a number of member clinics of the American Association of Psychiatric Clinics for Children. The Association would like to hear from potential applicants even if their draft status is uncertain.

This training is in preparation for specialization in child psychiatry, and especially for positions in community clinics devoted wholly or in part to the out-patient treatment of children with psychiatric problems. Fellows receive instruction and supervision in diagnostic and therapeutic techniques with children, in utilization of the integrated services of the psychiatric clinic team, and in coordination of clinic effort with the work of health, welfare, and educational agencies in the community. There is considerable variation in the different clinics, owing to the fact that they are under different auspices and have various affiliations.

For further information and for application forms, write to Miss Mary C. Bentley, Executive Assistant, American Association of Psychiatric Clinics for Children, 1790 Broadway, Room 916, New York 19, N. Y.

From Great Britain— Two new health records for England and Wales were set up in 1950. The stillbirth rate (provisional) and the infant mortality rate were the lowest ever recorded in Britain.

The stillbirth rate was 22.6 per 1,000 total births. The infant mortality rate fell to 29.8 per 1,000 live births, the first time the rate has been below 30. The infant mortality rate has been halved in less than 10 years; in 1941, the rate was 60 per 1,000 live births.

Children's Bill of Rights— Plans have been completed under which all new parents in New York State will receive copies of the Children's Bill of Rights originated by the New York State Youth Commission. Through the cooperation of the State department of health, copies of the bill of rights are sent to each local agency responsible for the issuance of birth certificates. These agencies forward a miniature bill of rights to new parents with the birth certificate.

Attractive copies of the Children's Bill of Rights, size 17 inches by 22 inches for agency use and size 8½ inches by 11 inches for home use, are available from the New York State Youth Commission free of charge.

Texas— A project to foster improved mental-health services in the public schools through cooperative community planning has been developed as a joint activity of several State and local agencies in the fields of health, education and welfare. The State legislature in 1949 appropriated funds which enabled school districts, many for the first time, to employ nurses, counselors, and visiting teachers. A State-wide committee on the integration of school nursing, counseling, and visiting-teacher services in local school systems suggested some months ago that a study be made in one of the school districts in order to clarify the functions and interrelationships of these newly established positions. Accordingly, the State department of health and the Hogg Foundation for Mental Hygiene of the University of Texas have jointly financed a special survey, working closely with the State department of education. Harlingen (population 25,000) was selected as the location for this survey, which will result in an analysis of the reasons for success and failure of the various components. The project will be written up at the end of the school year. Included among the private organizations giving consultation are: the Texas Guidance Association, the Texas Visiting Teachers Association, the State Organization for Public Health Nurses, and the National Association of School Social Workers. A local citizens' advisory committee has been set up to work with the superintendent of schools and his staff in Harlingen.

UNICEF — Five million pounds of cheese have been purchased by the United Nations International Children's Emergency Fund (UNICEF) for child-feeding programs.

Half the cheese—bought from the U. S. Department of Agriculture—goes to Yugoslavia, where a million children, in need because of last summer's drought, will benefit.

Greece will get 2 million pounds to help feed 580,000 children, and Israel 150,000 pounds for some 40,000 children.

A quarter of a million pounds of cheese is being sent to Latin America; 100,000 pounds each to Costa Rica and Nicaragua, and 45,000 pounds to Guatemala.

• CALENDAR

July 1–6—National Education Association. Eighty-ninth annual meeting. San Francisco, Calif.

July 22–28—National Farm Safety Week. Eighth annual campaign. Information from National Safety Council, 425 North Michigan Avenue, Chicago 11, Ill.

Aug. 5–16—World Assembly of Youth (WAY). Invited by the Young Adult Council of the National Social Welfare Assembly. Cornell University, Ithaca, N. Y.

Aug. 27–31—National Council on Family Relations. Annual conference. Lake Geneva, Wis.

REGIONAL CONFERENCES

American Public Welfare Association.

July 9–10—Southwest States, Oklahoma City, Okla.

Sept. 6–8 — Northeast States, Swampscott, Mass.

Sept. 20–22 — West Coast States, Oakland, Calif.

Oct. 1–2—Southeast States, Nashville, Tenn.

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Coordinated State Planning to Combat Poliomyelitis.

Emotional Aspects of Convalescent. By Milton J. E. Senn, M.D.

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